SEXUAL DYSFUNCTION

THIRD EDITION

A Guide for Assessment and Treatment

JOHN P. WINCZE
RISA B. WEISBERG

ebook

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1
Overview

We began our second edition with the statement "Interest in sexual behavior increased dramatically in the last two decades." Now, 14 years later, the "interest" has continued unabated and there are new developments in many fields that have contributed to our assessment and treatment of sexual dysfunction. While most major contributions have come from urology and cognitive-behavioral psychology, we have also benefited from a diverse array of other specialties including gynecology, primary care, cardiology, evolutionary psychology, neuroscience, epidemiology, and anthropology. The term "sexual medicine" combines medical practice and psychology and may be the best term that defines the state of the science today and reflects the contributions of multiple subspecialties from both fields. This term is not without its detractors, however, who fear an overmedicalization of the field and focus on function rather than the complexities inherent in dealing with any human sexuality issues (Tiefer, 2007, 2009). It is our intention in this third edition to bring to the reader the relevant developments in *all* fields that have brought us to our current status for the assessment and treatment of sexual dysfunction for men and women. The treatment model that is emphasized in this book is the *biopsychosocial model* as described by Berry and Berry (2013). This model emphasizes the multidimensional and multicausal phenomenon of sexuality that demands psychological and biological treatment strategies (McCarthy & McDonald, 2009b).

We are now more aware than ever that the assessment and treatment of sexual problems is an area that demands integration of a multidisciplinary approach. While there are certainly sexual dysfunction cases that have a purely medical or a purely psychological etiology and may benefit from a specific medical or psychological intervention, most cases benefit from at least a multidisciplinary assessment to allow for the most focused and efficient treatment. Even when sexual problems are identified as having a

purely medical or purely psychological etiology, the best treatment strategy may utilize both medical and psychological interventions. For example, men experiencing erectile dysfunction (ED) following prostate cancer surgery may benefit greatly from psychological input that helps them and their partners to accept changes in their sexual behavior and that also provides guidance in maintaining or even increasing sexual intimacy. On the other hand, a young man with no medical problems who is experiencing ED may benefit from a program using phosphodiesterase type 5 (PDE-5) inhibitors (Viagra, Cialis, Stendra, or Levitra) as an adjunct to a psychological program that is focused on building confidence and sexual approach behavior. There is no human problem that we can think of that benefits so dramatically from an integrated multidisciplinary approach than the assessment and treatment of sexual dysfunction. To achieve the most comprehensive and effective assessment and treatment approach, we endorse the "*concurrent* multidisciplinary approach" advocated by Binik and Meana (2009).

Binik and Meana (2009) explain that approach involves a coordinated and concurrent treatment among different disciplines. This is an improvement over the "serial multidisciplinary approach" in which one specialty would refer to another specialty for treatment and wait for a referral back once a specific problem was resolved. The concurrent model endorses coordinated ongoing collaboration and treatment. Although untested by controlled outcome research, it is intuitive that the concurrent model is more efficient and most likely shortens overall treatment by months. In addition, it is much more likely that the concurrent approach will help patients with compliance and investment in treatment. The reason for this is that patients are easily discouraged and embarrassed by their sexual problem and may avoid treatment if they encounter any barriers or "slowdowns."

We both have experience in working in a Men's Health Center that embraces the biopsychosocial model utilizing the concurrent approach and we are exposed to the advantages of such a model on a daily basis. On staff in the facility are two psychologists, two primary care physicians, three urologists, one physician's assistant, one physical therapist, one registered nurse, three medical assistants, and various support personnel. Such comprehensive treatment centers are rare at this time but most likely will become the norm in the future.

NEW MEDICAL DEVELOPMENTS

In our second edition of this book, we identified Viagra (sildenafil) as a new pharmacological agent that was promising to bring dramatic changes for the treatment of ED. Since its introduction on March 27, 1998, Viagra has been followed by other pharmacological agents: Levitra (vardenafil),

approved on August 19, 2003; Cialis (tadalafil), approved on November 21, 2003; and Stendra (avanafil), approved on April, 27, 2012. In addition to three dosage levels in pill form, Levitra is also now marketing a sublingual delivery with faster absorption under the name Staxyn (vardenafil HCl) approved on June 18, 2010. Cialis has developed a new approach also by introducing a low-dose daily pill. All of these agents have increased the options for treatment and have provided effective solutions for a wider population.

In addition to the increase in choices of PDE-5 inhibitors, the last 14 years have seen advances in the use of testosterone therapy for treating male sexual dysfunction. Although the use of testosterone therapy for treating ED and low libido in males has been in practice for well over 75 years (David, Dingemanse, Freud, & Laqueur, 1935), there has been a recent upsurge in interest in hormone replacement therapy for men and a variety of new and more effective delivery systems have been developed and are now available. Testosterone can now be applied daily in a gel form to the shoulders or in an applicator under the arms. In 2008, the U.S. Food and Drug Administration (FDA) also approved the use of Testopel, a pellet form of testosterone surgically implanted under the skin that lasts 3–6 months. Unlike some of the other delivery systems, Testopel carries no danger of transference to women and children.

The use of PDE-5 inhibitors and testosterone replacement therapy has been "game changing" in the treatment of male sexual dysfunction in the past 14 years. While there have been some advances in the medical treatment of female sexual dysfunction during the same time period, the advances have been far less dramatic and have not captured the attention of the news media as have the treatments for males. The use of the transdermal testosterone patch has shown some efficacy in treating postmenopausal women with low sexual desire (Buster et al., 2005; Simon et al., 2005). In addition, Meston, Rellini, and Telch (2008) have shown some benefit of gingko biloba extract on women experiencing low sexual desire. Neither of these pharmacological approaches have gained widespread use and have not enjoyed convincing controlled research support but do nonetheless represent some of the current efforts and hopes for further advances to come.

Medicine has also brought to our attention during the past 14 years the importance of the metabolic syndrome and cardiovascular disease in contributing to sexual dysfunction in men and women. The metabolic syndrome is characterized by abdominal obesity, dyslipidemia, and hypertension and was described almost 40 years ago (Haller, 1977; Singer, 1977). The relationship between the metabolic syndrome and sexual dysfunction in men and women has increasingly become a focus of our attention and is now routinely screened for and treated as part of an overall approach to the assessment and treatment of sexual dysfunction in men and women

(Esposito et al., 2005; Meuleman, 2011). Men and women presenting with sexual dysfunction who fit the criteria for the metabolic syndrome are likely to be encouraged to make important life-style changes such as diet, weight loss, and exercise as part of an overall treatment program that addresses sexual dysfunction.

We have also become increasingly aware of the relationship of cardiovascular disease and ED in males (Jackson, 2009; Miner & Kuritzky, 2007). ED may be an early warning sign of a future cardiovascular event. Since penile arteries are the smallest arteries in the male vascular system, they may be the most easily compromised as vascular disease progresses. Because of our awareness of this relationship, men presenting with ED are now more likely to be screened to determine the overall health of their vascular system. Assessment and treatment of vascular disease are consequently becoming a familiar part of our overall treatment for sexual dysfunction in men.

One additional new development in the past 14 years has been the focus on penile rehabilitation following prostate cancer surgery. In spite of advances in robotic surgery and "nerve-sparing" procedures, almost all men following this treatment experience a period of ED. The period of ED may be as brief as a month or may last up to 2 years or more before there is partial or full recovery. For some men there is no recovery at all and a variety of pharmacological protocols and surgery may be chosen to restore erections. During the period of time following prostate surgery the penis is continuously flaccid and consequently may be susceptible to permanent damage due to a decreased oxygenation of the blood that may result in fibrosis (scarring), loss of flexibility, and shortening. It is now common urological practice to engage men in a penile rehabilitation program prior to surgery and within 3 months following surgery. The program combines the use of PDE-5 inhibitors, vasoactive urethral gels, or vasoactive injections for the purpose of stimulating blood flow to the penile tissue. An important part of penile rehabilitation is couple therapy, which helps couples increase intimacy and sexual pleasure without a focus on intercourse (Alterowitz & Alterowitz, 2004).

NEW DEVELOPMENTS OUTSIDE OF MEDICINE

The assessment and treatment of sexual dysfunction derives benefits from a variety of disciplines. In addition to technical and procedural advances, our knowledge base of human sexuality is always increasing with new information coming from such diverse disciplines as epidemiology, anthropology, and evolutionary psychology. This is extremely important since imparting accurate information to sexually troubled men and women is a major

ingredient in most treatment protocols. When a therapist or physician is describing normative sexual behavior in terms of age, gender, or function to a worried patient, such information is dependent on the scientifically sound observations of researchers. Over the past 14 years we have benefited from the efforts of many scientific studies that will be cited throughout this third edition.

There have also been some advances in specific areas of psychotherapy for the treatment of sexual problems. We agree with Binik and Meana (2009) that it is inaccurate and misleading to refer to what we do in the treatment of sexual dysfunction problems as "sex therapy." While the psychological treatment of sexual problems may include specific psychotherapeutic procedures such as cognitive-behavioral therapy or *in vivo* desensitization, there is no actual discipline of "sex therapy" that is promulgated from a described theoretical basis. Rather, "sex therapy" is at best a combination of providing information and applying therapeutic techniques for treating sexual problems and treating all relevant contributing factors. Nonetheless, the term "sex therapy" is universally used in spite of the fact that it is subject to a variety of definitions and a potpourri of procedures. We are not attempting to disabuse our readers from using this term but rather alerting those readers to the inaccuracy of the term.

Keeping in mind that there is no specific discipline of sex therapy, we do note advances in the psychotherapeutic treatment of sexual problems over the past 14 years. Most noteworthy are contributions from cognitive-behavioral therapy that have described important process issues contributing to sexual dysfunction vulnerability (Nobre & Pinto-Gauveia, 2006a, 2006b; Gomes & Nobre, 2012) and outcome studies that have identified the efficacy of therapeutic techniques for specific populations (LoFrisco, 2011). We also have greatly increased our knowledge base over the past 14 years in many diverse areas such as masturbatory behavior (Gerressu, Mercer, Graham, Wellings, & Johnson, 2008), aging and sexual activity (Kontula & Haavio-Mannila, 2009), and diabetes and female sexual functioning (Giraldi & Kristensen, 2010) to name a few. Throughout the text, we will cite relevant studies that have helped to increase our knowledge base for better patient care.

In addition to advances in specific therapeutic techniques for treating sexual dysfunction and advances in our knowledge base concerning human sexuality, the past 14 years have witnessed an unprecedented mass media marketing campaign for the treatment of ED. Daily TV ads for Viagra, Cialis, and Levitra have not only increased our awareness of the problem of ED but have legitimized the treatment of all sexual problems. We have also been inundated with information available on the Internet about every conceivable sexual problem. We can now view a video lecture on "penile rehabilitation" or treatment for genito-pelvic pain/penetration disorder

(vaginismus) including ordering information for a set of dilators. We can now order any sex toy anonymously from our home computer, view any type of pornography imaginable, or follow a detailed "sex therapy" course. Unfortunately, it is not always easy for people to sort out fact from fiction and some people may invite harm rather than cure. For example, there are some websites for insecure and unsuspecting men who wish to enlarge their penis. The techniques for penis enlargement are usually endorsed by so called "experts" and presented as "proven" but the actual results are bogus at best and physically harmful at worst.

Those of us who treat sexual dysfunction problems in today's world are faced with a much more knowledgeable patient population who may harbor strong ideas about the course of treatment. Today's patient population seeking help for sexual dysfunction problems may also be more convinced about certain false beliefs "because they read it on the Internet." This requires today's health professionals who treat sexual problems to continually keep pace with new developments.

THE CURRENT DIAGNOSTIC SCHEME

Although several diagnostic approaches have been proposed to classify the sexual dysfunctions (e.g., Schover, Friedman, Weiler, Heiman, & LoPiccolo, 1982), the diagnostic scheme that has been most widely adopted for sexual dysfunctions is that contained in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM). This series of manuals was developed to aid mental health care professionals in the diagnosis and treatment of the so-called "mental disorders." (The first edition of the DSM appeared in 1952, and new editions appeared in 1968 and 1980; the third edition was revised in 1987; the fourth edition was published in 1994 and its text revision, DSM-IV-TR, in 2000; the fifth edition, DSM-5, was published in May 2013.) Although the manual was not developed for sex therapists, it contains diagnostic categories and criteria for the most commonly seen sexual difficulties.

There are 10 major diagnostic categories for sexual dysfunction in DSM-IV-TR: hypoactive sexual desire disorder (includes males and females), sexual aversion disorder, female sexual arousal disorder, male erectile disorder, female orgasmic disorder, male orgasmic disorder, premature ejaculation, dyspareunia, vaginismus, and substance-induced sexual dysfunction. All 10 of the dysfunctions identified in DSM-IV-TR should be further conceptualized along two dimensions. First, they may be characterized as "lifelong" (also known as "primary") or "acquired" (also known as "secondary"). Second, a dysfunction may be "generalized" (i.e., occurring across all sexual situations and partners) or "situational" (i.e., limited

to certain situations and partners). These distinctions are believed to be important with respect to both etiology and treatment. DSM-IV-TR represented an improvement over previous editions of the DSM but was still far from perfect. The primary limitation within sexual dysfunction diagnosis is the inherent subjectivity of criteria in most categories. Terms such as "minimal sexual stimulation" or "normal sexual excitement" leave much to clinical judgment.

Despite their limitations, DSM-IV-TR classifications continued to be used in professional journal articles, by most health professionals (from whom referrals may originate), and by insurance companies (for third-party reimbursement). It should be noted, however, that most insurance companies still do not reimburse for treatment of sexual dysfunction. Often, a diagnosis of anxiety disorder or depression is justifiable.

The work on DSM-5 began in 2006 with the appointment of David Kupfer, MD, as chair and Darrel A. Regier, MD, MPH, as vice chair of the DSM-5 Task Force (Zucker, 2010). The entire process of developing DSM-5 has had its share of controversy and is much too involved to be reviewed in this book. Readers interested in the issues and details can simply Google "DSM-5 Controversies" for further information. DSM-5 purported to make changes based on advances in research and new understandings of mental health problems, and consequently ended up eliminating some diagnostic categories, refining some existing categories, and creating new ones. Our book will subscribe to the DSM-5 categories but it is worthwhile to address briefly the changes compared to DSM-IV-TR. Although there have been many published articles related to the new sexual dysfunction categories and reasons for change, a succinct review of all of the major issues can be found in the April 2010 issue of *Archives of Sexual Behavior*, (Vol. 39, No. 2, pp. 217–303). A summary of the changes found in DSM-5 compared to DSM-IV-TR can be found in Table 1.1.

The major issues as can be seen in Table 1.1 are that the categories of female sexual arousal disorder and hypoactive sexual desire disorder are now collapsed into the single category of female sexual interest/arousal disorder, and dyspareunia and vaginismus are now collapsed into the single category of genito-pelvic pain/penetration disorder. Additionally, the category of sexual aversion disorder has been removed entirely as a sexual dysfunction disorder and has been classified as a specific phobia disorder. Further discussion of reasons for these changes will be addressed in the text under each disorder.

Sexual Deviations, Dysfunctions, and Dissatisfaction

The DSM diagnostic scheme includes the sexual deviations (i.e., paraphilia), as well as sexual dysfunctions. Paraphilia is a disorder in which

TABLE 1.1. Comparison of Diagnostic Categories between DSM-IV-TR and DSM-5

DSM-IV-TR categories	DSM-5 categories
Male erectile disorder	Erectile disorder
Female orgasmic disorder	Female orgasmic disorder
Male orgasmic disorder	Delayed ejaculation
Premature ejaculation	Premature (early) ejaculation
Female sexual arousal disorder	Female sexual interest/arousal disorder
Hypoactive sexual desire disorder (including both males and females)	Male hypoactive sexual desire disorder
Dyspareunia; vaginismus	Genito-pelvic pain/penetration disorder
Sexual aversion disorder	(now classified under specific phobias)
Substance-induced sexual dysfunction	Substance/medication-induced sexual dysfunction

an individual experiences recurrent and intense sexual urges and fantasies involving either (1) nonhuman objects (i.e., a fetish), (2) suffering or humiliation of oneself or one's partner (i.e., sadomasochism), or (3) nonconsenting partners (e.g., pedophilia, exhibitionism, frotteurism). Assessment and treatment of the paraphilias are not covered in this book. (Interested readers are referred to *Archives of Sexual Behavior,* 2010, Vol. 39, No. 2, pp. 304–426; Kafka, 2000; Laws, 1989; Laws & O'Donohue, 1997; Wincze, 2000.)

However, knowledge of the assessment and treatment of paraphilia or atypical sexual behavior (that does not meet the criteria for paraphilia) is important for assessment and treatment of sexual dysfunction. Unusual types of sexual preferences or stimulation are at times at the root of sexual dysfunction in both men and women. Incorporating or controlling the atypical sexual behavior of one partner within a couple's sexual practices may be an important component of the treatment of sexual dysfunction. Therapists treating sexual dysfunction problems can best serve their patients by being knowledgeable of and comfortable with "atypical" sexual behaviors.

In addition to being willing to explore, understand, and accept a person's unusual sexual practices and preferences, the therapist dealing with sexual dysfunction problems must also understand and accept that not everyone is concerned or distressed by their sexual dysfunction. Indeed, DSM-5 includes the criteria of distress and/or impairment.

Thus, a person may be "dysfunctional" but not necessarily dissatisfied. In a landmark study published in the *New England Journal of Medicine*, Frank, Anderson, and Rubenstein (1978) investigated 100 happily married heterosexual American couples. These researchers attempted to determine

the frequency of sexual dysfunctions experienced and the relationship of these problems to sexual satisfaction. Although over 80% of the couples reported that their marital and sexual relations were happy and satisfying, 40% of the men reported erectile and ejaculatory dysfunction, and 63% of the women reported arousal or orgasmic dysfunction! Even more surprising was the finding that the number of dysfunctions was *not* strongly associated with overall sexual satisfaction. These findings have been corroborated in a similar study conducted by Nettelbladt and Uddenberg (1979) in Europe. These authors reported that sexual dysfunction was *not* significantly related to sexual satisfaction in their sample of 58 married Swedish men.

These empirical findings remind us that sexual health involves more than just intact physiology and typical "functioning" (i.e., progression through desire, arousal, and orgasm phases). In our culture and in many others as well, sexual health is enhanced to the extent that it occurs in a rich interpersonal context that involves respect and trust, open lines of communication, and mutual commitment to all aspects of the relationship. (This is not to say that other approaches to sexual behavior are wrong, but rather to describe the conditions under which sexual satisfaction is maximized.) Sexual health is most likely to occur in individuals who are psychologically as well as neurologically, hormonally, and vascularly intact. Because existing diagnostic schemas, which focus exclusively on sexual "functioning," cannot encompass the richness of sexual health, such schemas (and diagnoses in general) have been criticized (e.g., Schover et al., 1982; Szasz, 1980; Wincze, 1982). This limitation notwithstanding, most scientist-practitioners find the DSM classification scheme useful for communicating among themselves, for presenting information about subclasses of problems, and for treatment planning. Indeed, the existence of the diagnostic system allows researchers to conduct epidemiological studies in order to determine the frequency with which disorders occur.

PREVALENCE OF THE SEXUAL DYSFUNCTIONS

With the recent explosion of interest in sexual dysfunction due to pharmacological treatments, there is every reason to believe that sexual dysfunctions are prevalent psychological disorders in the general population. Simons and Carey (2001) point out that although sexual disorders tend *not* to be included in large-scale epidemiological studies, there have been a multiplicity of empirical studies since 1990 that provide data on sexual dysfunctions. Comparing various prevalence rates across studies can be misleading, however, because studies differ in research methodology, definition of sexual disorders, and the sample under study (e.g., a sample

drawn from a diabetes clinic cannot be compared to one drawn at random from a community). Nonetheless, we now have some confidence in the prevalence range for most sexual dysfunctions within the general population. Community samples indicate a current prevalence ranging up to 3% for male orgasmic disorder, 5% for ED, 3% for male hypoactive sexual desire disorder, 10% for female orgasmic disorder and 5% for premature ejaculation (Simons & Carey, 2001). These prevalence data are consistent with anecdotal evidence from practicing social workers, psychologists, psychiatrists, and primary care nurses and physicians whose patients complain frequently about sexual dysfunction problems.

ETIOLOGY OF THE SEXUAL DYSFUNCTIONS

To treat sexual dysfunction or dissatisfaction effectively, it is helpful (but probably not necessary) to understand how that dysfunction or dissatisfaction developed. Unfortunately, our understanding of the cause(s) of the sexual dysfunctions remains incomplete. Moreover, much of our understanding comes from clinical observation rather than well-controlled research. As in the study of disease and psychopathology, this is not unusual; however, we do need to be mindful of the methodological limitations of such quasi-experimental research, cautious about our judgments, and continually open to new clinical and research data.

With these caveats in mind, we are nonetheless confident about the following general statements regarding the etiology of the sexual dysfunctions:

1. In most cases, sexual difficulties are multiply determined; that is, there is usually not just a single cause for a problem; rather, one can expect to find an array of factors that contribute to the development of a sexual difficulty. Appreciation of this principle can help to explain why treatments need to be customized to the individual, as well as why treatments need to be empirically eclectic, multimodal (Lazarus, 1988), or broad-spectrum (LoPiccolo & Friedman, 1988) rather than dogmatically designed and narrowly focused.

2. Within such a multicausal context, causes can be organized for communication purposes into three temporal categories (Hawton, 1985). First, "predisposing" factors are those prior life experiences (e.g., childhood sexual trauma) and inherited characteristics (e.g., diabetes) that make a person vulnerable to certain types of dysfunction. These predisposing factors serve as diatheses that place an individual at risk; predisposing factors may be necessary, but they are rarely sufficient to produce a dysfunc-

tion. Second, "precipitating" (or triggering) factors (e.g., stress associated with job difficulties) are those life events and experiences associated with the initial onset of a symptom or dysfunction. A precipitating factor serves as the proverbial "straw that broke the camel's back." Third, "maintaining" factors (e.g., lack of privacy, performance anxiety) are those ongoing life circumstances or physical conditions that help to explain why a dysfunction persists.

3. Causes can also be classified, again for heuristic purposes, into three human systems or frames of reference. First, causes may be inherently biological or medical. Thus, for example, the presence of penile microangiopathy (i.e., small-vessel disease) in a middle-age male diabetic can cause erectile difficulties. Similarly, the hormonal changes that can accompany menopause in women can produce vaginal dryness and dyspareunia. Second, causes can be psychological in nature. Gross disturbances in reality testing (e.g., paranoid delusions), major depression, and serious anxiety disorders have all been implicated in the pathogenesis of sexual dysfunction. Equally important psychological contributions to dysfunction include negative body image and performance anxiety (fear of negative evaluation, hypervigilance, or rejection). Finally, causes can arise from a person's social context. At the dyadic level, factors such as poor communication and relationship inequalities can foster sexual dysfunction. Larger sociocultural influences, such as sex-role or religious proscriptions, may also have an impact upon sexual functioning. We are also increasingly aware of the importance of the environment under which sexual activity occurs. In this respect, we have found the lack of privacy, the presence of pets, and disparate work schedules all have been identified in certain cases as significant contributors to sexual dysfunction.

In summary, we propose that the etiology of most sexual dysfunctions will be multiply determined, involving the transaction of biological, psychological, and social factors over a period of time. Thus, a major challenge for us as health professionals is to recognize these multiple sources of influence, and to appreciate that sexual dysfunction represents but one manifestation of a complex process. As our knowledge of etiology increases, it is likely that we will also develop more reliable and valid assessments, as well as more efficacious treatments.

ASSESSMENT AND TREATMENT

We have divided this book into four discrete sections. Part I follows the new DSM-5 classification system and includes the description and clinical

presentation of each disorder. The description is the DSM-5 criteria, while clinical presentation is how each disorder may be presented by patients. In many cases, for example, there may be a very different presentation of a specific disorder depending on the age of the patient. In addition to the description and clinical presentation, we present information on the prevalence of the disorder and its etiology. We also use clinical case material to illustrate each disorder.

In Part II, we discuss the assessment model for sexual dysfunction and identify both medical and psychological assessment considerations. Further, we identify the common ingredients that are found in all assessment protocols and we identify assessment procedures that are unique to very specific types of problems.

Part III discusses both medical treatment and psychological treatment for sexual dysfunction problems. As in Part II, we identify procedures that are common across all disorders as well as protocols that are specific to each disorder. We also discuss the strategies for working with couples as well as those for working with individuals without partners.

Finally, in Part IV we address important issues for all health care professionals who may wish to become more directly involved in assessing and treating men and women experiencing sexual dysfunction. We feel that it is important to understand the unfortunate development of a plethora of inadequate treatment programs and pharmaceutical products promising complete cures for sexual dysfunction problems and why consumers are susceptible to such quackery. We will also discuss how health professionals can receive legitimate training in this field.

Throughout our book, we are strong advocates of the biopsychosocial approach to health care, which received increased attention in the training of many health care professionals as early as 1977 (Engel, 1977). This model has important implications for both assessment and treatment that will become manifest throughout this book. Clearly, this model requires continuing efforts to stay abreast of developments—not only in one's own discipline but also in related disciplines.

Second, we are equally committed to the scientist–practitioner model of health care training and delivery. This model, espoused by the American Psychological Association as its primary training approach, has been much misunderstood, misapplied, and subsequently criticized. However, as we understand it, this model requires practicing clinicians (1) to stay abreast of recent scientific developments and, more importantly, (2) to adopt an empirical approach to their work. We discuss each of these "requirements" in turn.

It is important to stay current and remain informed of recent advances, controversies, and other developments in our field. Certainly, the arrival of effective pharmacological treatments and other medical interventions for

some sexual dysfunction problems is a prime example of this. All clinicians working with male ED must now be informed of the advantages and limitations of PDE-5s and other medical approaches.

The recommendation that one adopt a scientific approach to one's work requires careful, ongoing assessment and critical self-evaluation (see Barlow, Hayes, & Nelson, 1984; Carey, Flasher, Maisto, & Turkat, 1984). We believe that a scientific approach is especially necessary in a controversial and understudied area such as human sexuality because there is an increased probability of conjecture and subjective (or even distorted) information. Thus, the scientist-practitioner approach, which sensitizes one to the need to be critical of current "knowledge," is especially valuable in a field that is susceptible to potentially harmful information.

Third, we believe that, throughout history, a wide variety of sexual practices and orientations have been inaccurately labeled as psychopathological, deviant, or abnormal. Therefore, with some obvious exceptions (e.g., coercive sexual practices with a nonconsenting partner), we try not to make value judgments regarding the "rightness" or "wrongness" of practices that are not universally approved in our culture (e.g., sexual activity involving more than two individuals). Instead, we call for continued research and study of these practices to increase our understanding of the richness and diversity of human sexual expression.

We have attempted to prepare a book that is equally applicable to male and female, as well as to gay, bisexual, and straight concerns. At points where our coverage seems biased or one-sided, please understand that this was not our intention; such instances may reflect the state of current knowledge or our inability to express ourselves as well as we would have liked.

Finally, we would like to encourage all professionals to adhere closely to the ethical principles of their disciplines. Because our own professional training is in psychology, we follow the guidelines proffered by the American Psychological Association. Further information is available from the *Casebook on Ethical Principles of Psychologists* (American Psychological Association, 1987), or from the state licensing boards of the various professions.

CASE ILLUSTRATIONS AS USED IN THIS BOOK

We are very sensitive to our patients' sexual orientation, cultural and ethnic background, and religious beliefs or nonbeliefs, and we strongly advocate that all health professionals also subscribe to a nonjudgmental sensitivity for their patients. When treating sexual problems, we often run into situations where a person's personal beliefs or cultural heritage may be in conflict with sexual goals. In all cases, we make every attempt to understand

the important influences on a person's beliefs and work within their belief system to obtain the goal(s) they wish to achieve. Whenever possible we try to include input from a patient's religious or cultural leader with the patient's consent if the sexual goals seem to be in conflict with beliefs. For example, exposure to erotica or masturbatory practice as part of therapy may be an effective and logical procedure for a specific sexual dysfunction problem but conflict with a person's religious or cultural beliefs. Such therapy suggestions may benefit from a person's religious leaders' guidance. When therapy procedure designed to meet a patient's goals conflict with the person's cultural or religious beliefs and the procedures are not endorsed by the person's cultural or religious leader, then the therapist must search for an acceptable alternative—albeit not as effective in the therapist's experience.

In presenting cases throughout this book, we make every effort to disguise the demographic information so that the identity of the patient cannot be determined. The important factors of diagnosis or treatment protocol, however, will not be changed.

PART I
The Sexual Dysfunctions

Part I discusses the seven unique sexual dysfunctions as they are presented in DSM-5 and found in Table 1.1. All of the sexual dysfunction categories are defined by specific symptoms as well as the criteria that "the problem causes clinically significant distress or impairment" and "the sexual dysfunction is not attributable to a non-sexual psychiatric disorder, by the effects of a substance/medication, by another medical condition, by severe relationship distress (e.g., partner violence) or other significant stressors." Although there are very specific symptoms that must be present to meet the criteria for a clinical diagnosis, many patients whom we deal with do not present with sufficient symptoms to meet the DSM-5 criteria for an official diagnosis, yet present with significant distress over their sexual problem. We will therefore discuss a range of patients who present for treatment whether or not they meet strict criteria for DSM-5 diagnosis since every clinician treating sexual dysfunction will encounter a very wide range of patients.

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Erectile Disorder

DESCRIPTION AND CLINICAL PRESENTATION

ED is the most widely recognized and studied of all sexual dysfunctions. Rosen, Miner, and Wincze (2014) point out that ED has been the focus of intensive scientific and public interest and intense commercial activity over the past two decades. With the development of Viagra and other PDE-5 inhibitors, more than 100 million men worldwide have received prescriptions for PDE-5 inhibitors and numerous websites have appeared providing descriptive information on ED as well as guidelines for assessment and treatment. With the iteration of the DSM, changes have occurred to reflect our increased understanding of the disorder and to increase the reliability and validity of the diagnosis. A review of the changes in the DSM diagnosis of ED is presented by Segraves (2010). Segraves (2010) proposed that DSM-5 criteria take into consideration the severity and duration of ED. Specifically, he proposed that the diagnostic criteria be present for a minimum duration of 6 months and on at least 75% of occasions. These changes were, in fact, adopted by DSM-5. Refer to the diagnostic criteria for male erectile disorder (302.72) as presented in DSM-5 (American Psychiatric Association, 2013).

Men presenting with concerns about ED may describe their problem in a number of ways. For some men, it is a failure to *obtain* an erection while for others it is a failure to *maintain* an erection. Still others have reported an ability to obtain and maintain an erection but a perception that their erection is softer than it "should be" or "used to be." Regardless of the description of their ED problem, men usually present with some degree of emotional concern ranging from mild upset to extreme anxiety and even suicidal thoughts. The degree of upset is usually more intense in a younger population compared to an older population (Rosen, Miner, & Wincze, 2014).

We have had some men present with a complaint of ED when, in fact, they have had only a single episode of ED within a few weeks of their clinic visit. In spite of the extreme brevity of their problem, they are most often as upset and worried as men whom we have treated who have had a much more long-standing problem of ED. On the other end of the continuum, some men with erectile dysfunction may report that they have been completely unable to obtain an erection for years under any circumstances. Such complete dysfunction is, in our experience, rare except when there is the presence of specific inhibiting medical conditions. It is more common for men to report that they are able to obtain an erection on some occasions or to obtain a partial erection that is too soft to achieve penetration; alternatively, they may report that they can achieve a full erection but are unable to maintain their erection long enough to permit penetration and ejaculation. For some men, the detumescence is extremely rapid and may occur within seconds. Some men report that full erections are possible during noncoital stimulation—for example, during masturbation or nocturnally during rapid eye movement (REM) sleep. The amount of tumescence and rigidity that a man achieves may depend upon the extent of physiological involvement (discussed further in the "Etiology" section).

As a result of their erectile difficulties, men often report that they are embarrassed, discouraged, depressed, and may avoid sexual encounters altogether. Many will have tried several "home remedies" such as self-medication with alcohol or other drugs, viewing erotica, or becoming involved with a different partner. These remedies typically fail. Part of the reason why such self-help strategies fail is that men may approach masturbation or affairs under less-than-ideal conditions; that is, they may often approach masturbation with the same attitude as when with a partner, namely, with a self-demand to "perform." Thus, such a man may masturbate to "see if it works" rather than masturbate because he feels sexual desire. Consequently, his focus is on his penis rather than on erotic stimuli.

Similarly, a man who attempts to "test the waters" with a new partner may be as performance-oriented as with his usual partner and may also feel guilty. Such "extrapartner" encounters often do not have the luxury of relaxed, unrestricted time and may end up feeling more like pressure than pleasure. It is interesting that some men have reported to us that if they are with a partner whom they do not care about they are able to function. However, for those men who have a failing experience with a different partner, it is usually looked upon as additional evidence of inadequacy. This may then lead them to further avoidance of all erotic stimuli. We have known some men with long-standing ED who report that they purposely avoid looking at sexy people and may turn away from TV if sexual encounters are even suggested because thinking about sex is associated with frustration and depression.

One additional note on how men present with ED is that most men seem to identify themselves as having ED even when the conditions under which sex occurs are unfavorable for sexual arousal. For example, men who have a sexual partner who may be critical, unappealing, or blatantly uninterested in sex still may identify themselves as having ED rather than identifying the wider circumstances. Men who are prone to self-blame may buy into the sexual myth that a real man should always be interested in sex and should always be able to function under any circumstances.

PREVALENCE

Kaplan, as early as 1974, had estimated that 50% of all men will experience erectile difficulties at some point in their lives (Kaplan, 1974). Following this early estimation, the prevalence of ED in specific male populations has ranged from 1% (Wei et al., 1994) to 86% (Prins, Blanker, Bohnen, Thomas, & Bosch, 2002). The extreme variation in prevalence rates is due to the fact that different studies use different measures, different definitions of ED, and different populations when estimating the prevalence of ED. In spite of the wide range of prevalence estimates for ED, it is clear that ED is a widespread problem effecting a large number of men throughout the world. Millions of men worldwide have received prescriptions for PDE-5 inhibitors, the media is flooded with advertisements for treating ED, and men's health clinics focused on treating ED are developing rapidly.

In looking at the epidemiological studies on prevalence and ED some general conclusions become apparent. Age is an important factor, with older men much more at risk for ED than younger men. The Massachusetts Male Aging Study (Feldman, Goldstein, Hatzichristou, Krane, & McKinlay, 1994) found that approximately 10% of men under 35 years of age experience ED while more than 50% of men over 60 experience ED. We also know that men with specific diseases such as cardiovascular disease, diabetes, and the metabolic syndrome have a higher prevalence of ED than men without these diseases (Grover et al., 2006). Finally, we know that certain health-risk factors such as smoking, obesity, and lack of exercise contribute to a higher prevalence of ED (Rosen, Miner, & Wincze, 2014).

ETIOLOGY

Because erectile difficulties continue to be studied more than any other sexual disorder, our understanding of the causes of ED is more advanced than those for other sexual dysfunctions. The current conceptualization of ED has advanced well beyond the "organic" versus "functional" dichotomy

that once characterized the field. Well-trained professionals now recognize that the etiology of acquired ED, in most cases, involves a complex interplay of biological, psychological, and social influences.

Biological Factors

Biological factors can be subdivided into indirect and direct factors. Indirect factors are any medical factors that are present but have no direct pathophysiology that causes sexual dysfunction. For example, chronic obstructive pulmonary disease (COPD) does not directly cause sexual dysfunction, but a man with COPD may feel out of breath during sexual activity and his breathlessness may cause him worry and result in erectile failure. Direct factors, such as diabetes, cardiovascular disease, and low testosterone, directly impact on the body's ability to respond sexually. The most important direct medical factors that inhibit male arousal (erections) are endocrinological, cardiovascular, neurological, and pharmacological. There are also surgical factors such as prostate surgery that may directly interfere with male erection. In all cases of a direct pathophysiology for ED, it should be noted that there is a continuum, or different degrees of impact. Consequently, any given factor such as diabetes may have little impact on a man's erectile response or may completely inhibit erectile functioning. The degree of impact depends on a number of factors including age, severity of the disease or condition, and the presence of other comorbid factors.

Endocrine deficiencies have long been suspected as a leading cause of erectile difficulties. This notion resulted from early research that established a relationship between low levels of plasma testosterone and erectile capacity (Werner, 1939). Additional methodologically superior research has provided only mixed support for the hypothesis that reduced testosterone levels are responsible for erectile dysfunction (Jones, 1985). For example, numerous reports document the fact that men with prepubertal levels of serum testosterone can continue to obtain adequate erections (e.g., Davidson, Camargo, Smith, & Kwan, 1983; Heim, 1981). In apparent contrast, other investigators of hypogonadal men have reported increases in the frequency of spontaneous erections following testosterone replacement (e.g., Salmimies, Kockott, Pirke, Vogt, & Schill, 1982). Subsequent, more fine-grained analysis suggests that testosterone may be more important to fantasy-based arousal (and sexual desire) than it is to externally stimulated erections (Bancroft & Wu, 1983).

Further support of this finding comes from research with healthy men with ED. Schiavi, White, Mandeli, and Levine (1997) found that testosterone administration to this population increased sexual activity (sexual desire) but did not enhance erectile capacity.

Low levels of testosterone in men may result in erection problems

subsequent to decreases in sexual desire (Rakic, Starcevic, Starcevic, & Marinkovic, 1997). We also know that when men with prostate cancer are treated with leuprorelin (trade name Lupron) to artificially reduce testosterone levels, they report a marked reduction in sexual interest and an inability to obtain an erection. Leuprorelin is also used to treat sex offenders since it dramatically reduces sexual desire and erectile capacity (Saleh, Berlin, Malin, & Thomas, 2007).

Testosterone treatment of men with low testosterone does not always reverse the erection problem. In an attempt to predict which men with low testosterone would most benefit from testosterone treatment, Rakic et al. (1997) found that higher luteinizing hormone (LH) levels and lower values of the testosterone-to-LH ratio (T/LH) were most significantly associated with good outcome of testosterone treatment. Furthermore, gradual onset of erectile problems and older age were also correlated with positive treatment outcome.

Despite these mixed findings, most experts agree that although hormonal factors can contribute to erectile dysfunction, they are rarely the sole or primary cause (e.g., Bancroft, 1984; Jones, 1985; Schover & Jensen, 1988). For example, recent research has shown that diabetic men with total testosterone (TT) levels below 403.5 ng/dl (–1) had a significantly higher incidence of ED than diabetic men with TT levels above 403.5 ng/dl (–1) (Ghazi, Zohdy, Elkhiat, & Shamlou, 2012). Thus, it is likely that the combination of diabetes and low testosterone contribute to ED to a greater degree than either factor alone.

Vascular diseases represent a serious threat to erectile functioning (Jackson, 2009; Miner, 2009). Because erection is primarily a vascular phenomenon (i.e., erection is achieved by a threefold increase in penile blood flow), malfunctions in either the arterial (i.e., inflow) or venous (i.e., outflow) systems are likely to result in erectile difficulties. There is considerable evidence that the prevalence of ED is increased in men with various expressions of vascular disease (Solomon, Man, Wierzbicki, O'Brien, & Jackson, 2002; Min, Williams, Okwusa, Bell, & Panutich, 2006; Burchard et al., 2001). In addition, there is accumulating evidence that ED may be an early warning sign of vascular disease (Chew et al., 2010; Miner, 2009). This is especially true of ED in males 49 years old or younger.

Neurological disease can also contribute to erectile difficulties. Potential etiological contributors include diseases of the cerebral hemispheres (e.g., epilepsy), the spinal cord (e.g., multiple sclerosis), the peripheral nervous system (e.g., diabetes, renal disease), and trauma (e.g., damage from pelvic cancer surgery or spinal cord injury). The most common neurologically based cause may be diabetes, which places men at high risk for neuropathy and subsequent erectile dysfunction (Weinhardt & Carey, 1996). However, neuropathy is not the only pathogenesis attributed to diabetes.

Diabetes not only affects endocrine factors but also vascular factors that in turn can impact on erectile functioning. In a recent review, Ertekin (1998) points out that there are four different types of diabetic erectile dysfunction:

1. Acute–subacute erectile dysfunction indirectly related to diabetes.
2. Chronic–progressive erectile dysfunction directly related to diabetes.
3. Acute–subacute erectile dysfunction directly related to diabetes.
4. Other conditions contributing to or producing erectile dysfunction.

Within each type, the onset and course of erectile dysfunction is different. As is the case with any disease state that might be implicated in sexual dysfunction, prior sexual history and other nonmedical factors must also be considered to obtain an accurate assessment of the sexual problem. For interested readers, Ertekin (1998) provides a concise and comprehensive review of the role of diabetes in sexual dysfunction for men and women.

Alcohol has long been known to impair male sexual arousal (penile rigidity and orgasm) as blood alcohol levels increase (Cooper, 1994). However, as Langevin et al. (1985) have pointed out, the pure physiological effects of acute alcohol ingestion on erectile functioning are difficult to determine because alcohol often enhances desire that may compensate for any degradation of physiological capability. In an attempt to tease out the pure physiological impact of acute alcohol ingestion on erectile capacity, Cooper (1994) looked at the impact of alcohol on nocturnal penile tumescence (NPT). Using RigiScan measures on a single subject, Cooper concluded that alcohol ingestion suppresses REM and thus delays NPT responding, but only at high dosages does alcohol impair erectile capacity. Individual differences will, of course, determine the impact of acute alcohol ingestion on sexual functioning, but in general low levels of alcohol do not appear to impair erectile capacity physiologically. In fact, alcohol at low levels is reported to have enhancing effects on sexual arousal/desire, but this may be due to expectancy as much as any specific pharmacological mechanism (Roehrich & Kinder, 1991). Acute alcohol ingestion in association with sexual behavior is undoubtedly widespread. Laumann, Gagnon, Michael, and Michaels (1994) found that about 9% of men and 6% of women report "frequent" ingestion of alcohol before or during sex.

Chronic alcohol abuse is much more likely to impair sexual functioning due to actual damage to the body. Neuropathies as well as testicular and liver damage occur as a result of chronic alcoholism. For men, liver and testicular damage result in lowered testosterone levels and possible gynecomastia (breast growth).

Fahrner (1987) reported the results of a study of 116 patients in an alcohol treatment program in Germany. Twenty-three patients (20%) reported frequent episodes of ED, and 26 patients (22%) reported very frequent or

continuous episodes of ED. Fahrner also cited numerous other studies documenting the higher prevalence of ED among chronic alcoholics.

The effects of other substances of abuse on erectile functioning are less well studied (Buffum, 1986). It has been suggested that the frequency of ED among heroin users is 28–43% and among methadone users 40–50% (Segraves, Madsen, Carter, & Davis, 1985); both estimates are considerably higher than the frequency found in the general population. Reliable estimates are not available for other commonly abused substances (e.g., amphetamines, marijuana, and cocaine). The illicit status of these drugs makes well-controlled studies in humans very challenging. Thus, we recommend strongly that your assessment include careful attention to substance use for all patients.

Numerous prescribed medications are implicated as causes of sexual dysfunction in both men and women (Crenshaw & Goldberg, 1996). Most consistently reported, however, are the antidepressant medications. In a review, Margolese and Assalian (1996) reported the effects of various antidepressants on the sexual functioning of men and women. They concluded that for sexual arousal, the tricyclic and tetracyclic antidepressants are most likely to impair erections and vaginal lubrication. Selective serotonin reuptake inhibitors (SSRIs) may also impair arousal but are most often associated with delays in orgasm.

Antihypertensive medications have also been implicated in impairment of erectile functioning (Bansal, 1988; Moss & Procci, 1982; Papadopoulos, 1989; Segraves et al., 1985). Critical examination of the research on this topic, however, finds few studies that provide support for this belief. In one of the methodologically strongest studies, Rosen, Kostis, Jekelis, and Taska (1994) investigated, prospectively, the effects of four beta-blockers (atenolol, metoprolol, pindolol, and propranolol) on sexual functioning in 30 healthy men. Over a 70-day period, the subjects received each of the four drugs and a placebo, and assessment of erectile functioning was obtained with measures of NPT. The results indicated that only minor, clinically insignificant decrements in tumescence were observed.

Additional studies on other antihypertensive agents have similarly revealed clinically insignificant impact on erectile functioning (Broekman, Haensel, Van de Ven, & Slob, 1992; Morrissette, Skinner, Hoffman, Levine, & Davidson, 1993). The evidence for suppression of erectile functioning associated with antihypertensive agents is not impressive (Rosen et al., 1994).

Psychosocial Factors

The most common psychosocial factor that contributes to ED is *performance anxiety*. Performance anxiety was identified in the early work of Kaplan (1974) as well as by Masters and Johnson (1970) and has contin-

ued as an important factor in most cases of ED. Men are generally more likely to experience performance anxiety because a man's sexual response is observable and both a man and his partner will be aware of the status of his erection. Performance anxiety may be the sole factor contributing to ED or it may accompany cases of ED even when the etiology is primarily medical.

The term "performance anxiety" is somewhat misleading since anxiety in a physiological sense may actually facilitate sexual arousal (Hoon, Wincze, & Hoon, 1977; Meston & Gorzalka, 1996). A more descriptive term might be "performance worry." Regardless of terminology, it is common for most men to experience erectile failure at some point in their lives; the question is, "Why are some men unaffected by the experience of erectile failure and continue without worry and with sexual success while other men are devastated by an episode of ED and worry to the point that all subsequent experiences are compromised?" There are also some men who have not had any sexual experiences yet worry so much about the possibility of ED that they avoid sex. Numerous clinical observations and research studies have shed some light on this phenomenon. Havelock Ellis, who is sometimes referred to as the "father of modern sexology," may have been the first to provide an astute and insightful observation about a man's susceptibility to experience the problem of ED. In his 1906 tome entitled *Studies in the Psychology of Sex,* he stated that men experiencing erectile dysfunction were "men of abnormally sensitive temperament" (vol. 2, part 3, p. 174). Although we do not know exactly what Ellis meant by "abnormally sensitive temperament," more contemporary research seems to be identifying a similar factor. The Massachusetts Male Aging Study (Feldman et al., 1994; Araujo, Johannes, Feldman, Derby, & McKinlay, 2000) identifies "submissive men" as more at risk for performance anxiety and ED.

The work of Barlow and his colleagues (e.g., Barlow, Sakheim, & Beck, 1983; Beck, Barlow, & Sakheim, 1983; Sakheim, Barlow, Beck, & Abrahamson, 1984) has been especially instrumental in delineating important psychological factors related to erectile failure. According to Barlow's (1986) model of erectile functioning, men with ED differ from men without sexual problems in their cognitive-affective response to a sexual performance demand. Whereas sexually healthy men respond to erotic cues with positive affect and the expectation that they will have a pleasurable experience, men with ED approach a sexual situation with negative affect and the expectation that things will not work out as they would like. These differing affective and cognitive states are thought to lead to differential attentional focus during sexual activity. That is, if a man with erectile problems expects to have erectile difficulty, to disappoint his partner, or to experience other negative outcomes, he is likely to allocate much of his attention during sex to worry about these issues, rather than to the

erotic and sexually exciting aspects of the encounter. As we often tell our patients, there is good reason that no one has ever made an erotic film featuring a man thinking, "This is never going to work. I'm not getting hard. My partner thinks something is really wrong with me. What if I never get hard again? What if my partner leaves me? Etc." This would be a horribly unarousing film! However, in effect, this is what many men with ED are playing in their own minds during sex. It is easy to understand how this focus on worry may lead to difficulty attaining or maintaining an erection.

In an ingenious series of studies, Barlow and colleagues compared men experiencing erectile failure to men not experiencing any erectile problems, building strong empirical support for the model. For example, a frequently replicated finding by these researchers has been that men with sexual dysfunction report greater negative affect than men without sexual difficulties, both before and after exposure to erotica (e.g., Abrahamson, Barlow, & Abrahamson, 1989; Beck & Barlow, 1986a, 1986b). The role of negative mood and affect has also been studied directly by manipulating affect in men without ED. These men evidenced significantly greater penile tumescence and subject arousal to erotica during an "elation" mood induction then during a control mood condition. A depressive mood induction was associated with significant decreases in penile tumescence (Mitchell, DiBartolo, Brown, & Barlow, 1998). Research has also supported the impact of expectancies on sexual arousal. Bach, Brown, and Barlow (1999) had men without sexual problems view erotic videos while their penile tumescence was measured in a lab setting. Half of the men were then given bogus negative feedback about their erections. Men who were informed that they did not get as firm an erection as the average participant in the study evidenced lowered expectancies regarding their ability to become aroused during a subsequent video. Further, these men had a significant decline in erectile tumescence during the second video.

Barlow's model is a feedback model. Because men have a history of sexual problems, they are more likely to approach the next sexual situation with negative affect and expectancies. This negative state then again leads to an attentional focus on nonerotic cues and low arousal. As such, this model explains the maintenance of erectile difficulty, after an original occasion of a less-than-desired erection. Weisberg, Brown, Wincze, and Barlow (2000) examined a possible means for how the feedback loop first begins. They proposed that after what might be a normative occasion of erectile difficulty, due to any number of circumstances (e.g., fatigue, stress), the explanation and attribution made for the incident of erectile difficulty may lead some men to experience negative thoughts and mood in a future sexual situation.

In a study of healthy males, Weisberg et al. (2000) exposed men to erotic tapes while recording subjective arousal and physiological measures

of penile circumference change. Men were then given false feedback stating that their sexual response was less than what was typical. Half of the subjects were told that the reason for their poor performance was most likely due to the poor quality of the videos (external attribution), and half were told that their poor performance was predictable because of personality characteristics regarding sexuality (identifying with questionnaires completed by the subjects, i.e., internal attribution). Subjects given the internal attribution showed less penile response than subjects given the external attribution, even though both groups were equal in previous video exposures. These results suggest that a self-critical attributional style may be one important factor contributing to erectile response in men.

More recently, Nobre and colleagues (Nobre, Pinto-Gouveia, & Gomes, 2006; Nobre & Pinto-Gouveia, 2009) have observed that men susceptible to ED are (1) much more likely to endorse myths about male sexuality (e.g., "a man always wants and is ready for sex"), (2) view themselves as incompetent and powerless, and (3) view their sexual problem as internal and stable. Collectively, all of the above factors contribute to worry about sexual performance and lead to and maintain ED.

Finally, we are also familiar with situations in which a loving and well-meaning partner may respond to a man's ED with emotions of tears, sadness, or anger and with words such as "Don't you love me?"; "Don't you find me attractive?"; or "Is there someone else?" All of these reactions, unfortunately, draw a man's attention to his failed sexual response and significantly contribute to hypervigilance and performance anxiety.

In addition to performance anxiety, a number of other psychosocial factors can contribute to ED. Comorbid mental health conditions that are often associated with ED include depression, generalixed anxiety disorder, obsessive–compulsive disorder, and paraphilic disorders. General stress in a man's life whether related to financial problems, conflicts at work, or family concerns may also be preoccupying and overwhelming and contribute to sexual problems generally and ED specifically.

Relationship problems may also be at the root of some ED problems. Men who are with partners who are uninterested in sex or who are unattractive to the man may lead to a situation in which a man has difficulty with arousal and ED. Similarly, significant marital conflict and anger at one's partner will also usually contribute to ED.

One final area of concern that must not be overlooked when considering psychosocial contributions to ED is the sexual environment. Lack of privacy, whether related to children with poor boundaries or pets in the bedroom, has often been noted as an interfering factor contributing to ED. Other environmental factors we have encountered in our clinical practice have been incompatible work schedules, sleeping in deceased parents' bedroom, a squawking parrot, and bedroom lighting.

CASE EXAMPLE: ERECTILE DYSFUNCTION IN FIRST AND SECOND MARRIAGES

Steve, age 54, came to our clinic complaining of ED with his new wife. In his first marriage of 20 years, he reported that his wife did not enjoy sex; after having two children, she stopped engaging in sex altogether. Steve reported many differences he had with his first wife. After 10 years of marriage he knew that he should get a divorce; however, he chose to stay in the marriage because of his children. Once his children were older, he then proceeded with a divorce.

Steve remained single for 4 years before he started dating Fran, age 52. During the 4 years before dating Fran, he dated a number of other women and experienced successful sexual relations but he stated that he never really cared deeply for any of the women he dated. He had actually known Fran from work for about 10 years and although he found her attractive, both were married with children (Fran had four children) and he never pursued the relationship. Upon learning about Fran's divorce, he then asked her out and both found their new relationship very rewarding. Steve described his initial sexual experiences with Fran as "unbelievably erotic" and successful. They dated for 1 year and then got married.

Within a year of marriage, Steve started experiencing ED. Initially, the ED was intermittent but over the course of 1 year, ED was occurring on almost every sexual encounter. He stated that he did not typically masturbate but he "tried" masturbating a couple of times and failed. These failures led to despair and then avoidance of sexual relations with Fran. He stated very emphatically that he was very attracted to Fran and he loved her very much but he did not want to disappoint her. Steve went to his primary care physician and obtained Cialis. This seemed to help Steve somewhat but he was still experiencing ED more than half of the time when he sought help at our clinic.

Comprehensive medical evaluation did not identify any medical conditions that could be contributing to Steve's ED problem. He had no symptoms of cardiovascular disease, hypogonadism, or metabolic syndrome; he had no substance abuse problems; and he was not taking any medications. Furthermore, he reported occasionally experiencing strong night-time erections. All evidence pointed to a more psychologically based etiology.

Steve recalled that his ED seemed to follow after one of Fran's children burst into their bedroom while they were having sex. Although they subsequently put a lock on their bedroom door, ED started to occur. Steve stated that he was self-conscious following this incident and also became very focused on his erection. Steve noted that he and Fran also had two small dogs that slept in their bed. He noted that on some occasions when they were attempting sex, the dogs were rubbing against him. The performance

anxiety persisted and definitely carried over into his attempts at masturbation. Although Fran stated to Steve that she was very supportive, she also stated that it was entirely his problem and not her fault because she was always available and always willing to have sex.

Couple therapy began with information to help Steve and Fran understand the concept of performance anxiety as well as the importance of creating a sexual environment free of the interference from their pets. The information was very helpful in removing blame and in engaging the couple to work together to solve *their* problem. Once the couple had a conceptual understanding of the origin and maintenance of their sexual difficulties, they were then instructed in sensate focus (see Chapter 14), which they found very helpful in restoring a positive sexual relationship.

Comment

This case illustrates some common factors found in many cases. Steve felt sexually rejected in his first marriage and desperately wanted his second marriage to work. His strong positive feelings for Fran inadvertently increased the importance of sex to the point of hypervigilance and self-monitoring. The presence of the small dogs that were previously ignored now became an additional source of distraction. Once a failure occurred due to the intrusion on his privacy, performance anxiety resulted in full force. The words from Fran were not reassuring and had the opposite effect of increasing performance worry. Attempts at private masturbation also met with failure because Steve focused on his erection rather than getting lost in erotic images and enjoying the sensations.

In this case, Steve entered the sexual relationship with Fran with some insecurity about his sexual performance and consequently was very invested in making sure sex worked. It appears that the initial excitement of a new sexual relationship helped him to focus on the eroticism rather than on his performance. Once the couple moved in together and the intrusion of privacy occurred, Steve seemed to shift his focus back to performance. The performance worry then maintained the ED problem. The successful outcome of this case was facilitated by the positive nonsexual relationship between Steve and Fran. Their very satisfying initial sexual experiences also reassured them of their attraction for each other and their ability to enjoy sex together.

3

Female Orgasmic Disorder

DESCRIPTION AND CLINICAL PRESENTATION

Orgasm in males is usually accompanied by ejaculation. Consequently, males have an objective marker of the experience of orgasm and typically have no trouble in identifying the occurrence of orgasm. Since women have no such marker, there can be difficulty at times in identifying whether or not an orgasm has occurred (Meston, Levin, Sipski, Hull, & Heiman, 2004). Indeed, the precise definition of orgasm remains somewhat elusive and without universally accepted agreement (Graham, 2010a; Mah & Binik, 2001). Nonetheless, definitions of female orgasm underscore the great variability that may be experienced between women as well as within a woman from one experience to the next (Meston et al., 2004; Graham, 2010a). The orgasmic experience usually includes descriptions of intense pleasure, genital sensations, involuntary rhythmic contractions, and an altered state of consciousness. This described orgasmic experience is shared by both males and females. Meston et al. (2004), however, proposes four differences between male and female orgasm:

1. Females, unlike males, may experience repeated or multiple orgasms.
2. Females may experience an extended orgasm.
3. Males and females may have different patterns of pelvic rhythmic contractions.
4. A male's orgasm cannot be interrupted once initiated while a female's orgasm can be interrupted.

One final difference between men and women regarding orgasm is that for men, the ability to experience orgasm appears to be independent of age (postpuberty), while for women there appears to be a learning curve

with older women much more likely to experience orgasm than younger women.

Since there is a great deal of subjectivity in the orgasmic experience as well as in the lack of a universal definition of orgasm, it is difficult to define what an orgasmic problem is. Care has to be taken, of course, not to overly pathologize any sexual experience and to take into consideration cultural, ethnic, and religious factors. Graham (2010) presents a review of the changes that DSM has gone through in arriving at the most current description presented in DSM-5 for female orgasmic disorder (FOD). Refer to the diagnostic criteria for female orgasmic disorder (302.73) as presented in DSM-5 (American Psychiatric Association, 2013).

FOD and all sexual dysfunction disorders in DSM-5 have taken into account the recommendations of Balon, Segraves, and Clayton (2007) and Segraves, Balon, and Clayton (2007) that specific criteria related to duration and severity should be added.

Women presenting with orgasmic disorder do not typically express the same degree of negative emotional intensity or desperation that men do who present with ED. While women who experience FOD may feel inadequate and upset, rarely do they feel that their partner will leave them because of the problem. Women are also able to more easily "fake" orgasm as illustrated in the classic movie *When Harry Met Sally*. The option to fake an orgasm may serve to reduce performance anxiety for some women. However, we have also seen cases in which the propensity to fake orgasm has likely served to maintain the problem. For example, Joanna consistently faked orgasm during the first 3 years of her relationship with Kim. Joanna now wishes that she were able to achieve orgasm with Kim and sought assistance at our clinic. However, Joanne feels strongly that she cannot tell Kim about this problem, and doesn't know how to explain to Kim her desire to try different types of stimulation, as Kim believes that Joanna has long been orgasmic with her. While it is certainly possible for men to fake an orgasm with penetrative sex, it is rarely mentioned by our male patients as an option.

Some women who have not achieved orgasm may, in fact, still experience sexual desire, sexual arousal, and sexual satisfaction. The interpretation of FOD as acceptable or unacceptable may be influenced by numerous psychological factors (i.e., knowledge, self-esteem, and self-confidence) as well as by interpersonal factors (i.e., partner pressure, knowledge, or satisfaction) and cultural/religious factors.

Finally, in describing FOD it must be emphasized that an orgasm is an orgasm and it does not matter how an orgasm is produced. While some theorists posit that there is a psychological superiority of a vaginal orgasm compared to a clitoral orgasm (Brody, 2007), most other researchers in the field disagree and point to survey and clinical evidence that most women do

not regularly achieve orgasm by vaginal intercourse (Graham, 2010a). The notion of the superiority of a vaginal orgasm can be traced to Freud, who posited that clitoral orgasms were a symptom of neurosis.

PREVALENCE

It is difficult to establish accurate prevalence rates for all of the sexual dysfunctions because of differences in the definitions used by researchers for each dysfunction under study (e.g., DSM criteria vs. less restrictive criteria); because of differences in the populations under study (e.g., clinic population vs. general population); and because of differences in research methodology used in various studies (e.g., structured clinical interviews vs. surveys). Consequently, reported prevalence rates vary widely for any specific sexual disorder. In establishing prevalence rates for women who are anorgasmic, we must also consider the fact that not all women are distressed by their lack of orgasm, and therefore would not meet DSM criteria. In a recent review of 11 epidemiological studies, Graham (2010a) found that the lowest prevalence rate of orgasmic disorder was 3.5% when DSM-III criteria were used and the highest rate of 34% was found when women were asked whether or not they were able to experience orgasm. The more restrictive DSM criteria produce a lower prevalence rate.

ETIOLOGY

Biological Factors

Morokoff (1978) provided an early overview of the determinants of female orgasm. Among the biological variables she identified, the condition of the pubococcygeal musculature seemed to be the one most likely to be associated with female orgasmic disorder. Subsequent research, however, has challenged her conclusion. Chambless et al. (1982) investigated the relationship of pubococcygeal condition to orgasmic responsiveness in 102 nonclinical subjects. Contrary to expectation, pubococcygeal strength was not associated with frequency or self-reported intensity of orgasm. Moreover, women with greater pubococcygeal strength did not report that vaginal stimulation contributed more to the attainment of orgasm; nor did these subjects rate vaginal sensations during intercourse as more pleasurable. A follow-up intervention study (Chambless et al., 1984) supported these earlier findings. In the 1984 study, females with a low frequency of coital orgasm were taught to use Kegel exercises to improve their pubococcygeal strength, and despite a significant increase in strength, no improvement in coital orgasmic frequency was observed.

Heiman (2002) identified a number of neurophysiological factors that have been implicated as potential causes of orgasmic difficulties; she notes that any disease, injury, or disruption that affects the sympathetic or parasympathetic nervous systems might impair orgasm in women. Goldstein and Berman (1998) suggest that atherosclerotic vascular disease may be a common cause. More recent evidence supports these earlier studies (Basson & Weijmar-Schultz, 2007; Graham & Bancroft, 2009).

The effects of hormonal variation on orgasm are also unclear, especially in older women. Sherwin (1985) studied eight women who had been maintained on a combined estrogen–androgen drug since undergoing hysterectomy (i.e., removal of the uterus) and bilateral oophorectomy (i.e., removal of the ovaries) 2 years previously. Although hormone replacement did influence sexual desire and arousal, rates of orgasm were unchanged. Similar findings were reported by Sherwin, Gelfand, and Brender (1985). However, in a third study, Sherwin and Gelfand (1987) found that orgasmic rates were enhanced following the administration of the estrogen–androgen preparation.

Ample evidence now documents negative effects of pharmacological medications on orgasmic functioning in women (Meston et al., 2004; Graham, 2010b). Treatment with the SSRIs commonly results in anorgasmia in women at follow-up evaluations (Margolese & Assalian, 1996; Shen & Hsu, 1995), although the mechanisms are not well understood (Meston & Gorzalka, 1992).

It appears that in some cases the side effects of some SSRIs and other psychoactive medications can be countered medically. For example, in one study, a 35-year-old woman with recurrent depressive illness was treated with sertraline and responded to the drug but complained of persistent loss of orgasmic quality and frequency (Grimes & Labbate, 1996). Her orgasms did not improve during a 2-week trial of cyproheptadine but, when treated with an injection of adjunctive bupropion, she reported a spontaneous orgasm.

The potential influence of chronic illness on orgasmic functioning, especially in older women, has also been investigated (Basson & Weijmar-Schultz, 2007). With a large sample of young female diabetics (mean age 33 years) and controls, Hulter (1999) has provided an excellent series of studies researching the impact of diabetes, multiple sclerosis, and various hypothalamo–pituitary disorders (HPD) on female sexual functioning. She found higher rates of anorgasmia in women with diabetes (14%), multiple sclerosis (51%), and HPD (69%) compared to the relatively low rate of 2% in healthy female controls.

One additional area of interest regarding biological factors and FOD is the study of women with spinal cord injuries. In a review of the literature in this area, Meston et al. (2004) found that although women with various

degrees of spinal injury experienced some degree of compromise in their orgasmic response, they nonetheless were orgasmic. In fact, physiological measures of orgasm and subjective measures of orgasm were indistinguishable between women with spinal cord injury and able-bodied women.

Recently, we have seen an increase in women believing that structural issues regarding their genitalia may contribute to anorgasmia. One such example was Elena, a single, 28-year-old Latina, who presented to our clinic with a history of lifelong anorgasmia. Elena stated that she had been dating her current partner for over a year, and that she was very much in love with him. She reported that she felt that she herself was disappointing him by being unable to orgasm, and that she was also disappointed, as she felt she was "missing out." Elena's partner did not attend our meetings. Elena reported being very embarrassed about the problem, and about discussing her sexuality. She stated that she couldn't imagine discussing it with her partner, and thus he was not aware that she was attending our clinic. Elena presented as shy during our meetings and rarely made eye contact when discussing sexual matters, though she was warm and friendly and notably more outgoing when discussing her family, work, and general issues. Elena reported growing up in a devout Catholic family and having very little sexual education. She stated that she was not led to feel that sex was a sin, but rather sex was just never discussed. Elena stated that she began to masturbate in her early 20s, only after hearing her friends discuss this behavior and becoming curious about it. She reports that prior to this time, she refrained from touching her genitals, as she believed that she could introduce infection in this manner. Elena had also had a couple of previous boyfriends with whom she was sexually active. She reported that during sex with a partner or masturbation, she would become aroused easily, but that her excitement would never build to the point of orgasm.

Elena had received extensive medical assessment from a gynecologist and a urologist prior to our visit. Her chart notes from these visits reported that there were no notable malformations of her external genitalia or internal reproductive organs. Her hormones levels were all within normal limits and her general health was excellent. Nonetheless, Elena was convinced that something was physically wrong and "abnormal." She had purchased some "aphrodisiac" pills at a local sex store and questioned us as to whether we thought these would help her, or if we could prescribe something else for her.

Treatment began with psychoeducation about her anatomy, normative sexual functioning, and the range of sexual responsiveness. Elena was also provided information about masturbation and encouraged to purchase a vibrator. At each of our meetings, however, Elena reported that she had been discussing her problems with friends, who all felt that something must be medically and physically wrong with her. At our last meeting, Elena

reported that she had been to South America where she had a consultation with a plastic surgeon recommended by a friend, as his rates were much less expensive than what she thought she might pay for surgery in the United States. Elena stated that this surgeon had diagnosed her with a "loose vagina" and "insufficient G-spot." Elena appeared greatly relieved to have a medical cause for her anorgasmia. She scheduled vaginal rejuvenation surgery with G-spot augmentation for the following month. Elena never returned to our practice.

Elena's case highlights a growing trend in genital plastic surgery. Genital plastic surgery, including labiaplasty, vaginoplasty, hymenoplasty, perineoplasty, and G-spot augmentation, has been marketed to women for cosmetic reasons, as well as touted as a potential treatment for sexual problems, including arousal and orgasm problems. Internet advertisements for these surgeries are prolific and these surgeries have been recently been increasing in popularity throughout the world. In the United Kingdom, the first decade of this millennium has seen a 300% increase in the number of female genital plastic surgeries performed yearly (Lowenstein et al., 2014). In the United States, rates of female genital plastic surgery rose 30% in just 1 year, from 2005 to 2006 (American Society of Plastic Surgeons, 2006). Despite the increasing popularity, there has been a paucity of research on the safety and efficacy of such surgery. Though a few published reports have indicated that women having such surgery report few complaints and improved sexual satisfaction (e.g., Goodman et al., 2010), these studies have not formally assessed sexual dysfunction/functioning, have not used standardized measures, and have not included a control group. Currently, due to this lack of empirical support, both the American College of Obstetricians and Gynecologists (ACOG; 2007) and the Society of Obstetricians and Gynaecologists of Canada (Shaw et al., 2013) caution physicians against performing such surgeries for purposes of improving sexual functioning. Physicians are also cautioned about the paucity of information regarding potential side effects such as altered sensation and dyspareunia (ACOG, 2007).

Psychosocial Factors

Before reviewing the myriad of psychosocial factors that have been explored in relationship to FOD, it is important to point out that the lack of orgasm in women seems to be identified as stressful in only a minority of women experiencing this condition (Graham, 2010a). Compared to men, women are less likely to define the success of a sexual encounter on the basis of the occurrence of their orgasm. Meston et al. (2004) raise the question, however, whether or not today's woman may attach more importance to orgasm than women in the 70s and 80s. Identifying orgasm as important

does not mean that the lack of orgasm is distressing although this association awaits empirical verification.

In women who are distressed by their anorgasmia, there is often an accompanying state of performance anxiety analogous to a male's experience of ED. The focus of attention is placed on the outcome rather than the enjoyment of the sexual process. A woman caught up in this cycle will measure her success on the basis of the occurrence of her orgasm much as a man experiencing ED will focus on his erection. The focus on performance, whether on orgasm for women or on erection for men, becomes a vicious cycle that is self-defeating and leads to more "failure' and sexual avoidance.

For all sexual dysfunctions, there is a list of the "usual psychosocial/cultural" factors, including education level, social class, religion, mental health, and relationship that may inhibit sexual expression. Basically, any nonmedical factor that serves to restrict or interfere with sexual comfort or the utilization of erotic input is suspect in contributing to a diminished positive sexual response. For example, Laumann et al. (1994) found that regarding orgasmic capacity, women with higher education and less religiosity were generally more orgasmic. Meston et al. (2004), however, conclude that there are no consistent empirical findings that any psychosocial factors alone differentiate orgasmic from anorgasmic women.

More recently, Nobre and Pinto-Gouveia (2006a, 2008, 2009) have presented a series of studies that have looked at sexual beliefs and cognitive schema in men and women with a diagnosis of sexual dysfunction compared to men and women without sexual problems. Their findings show that men and women with sexual dysfunction are more likely to interpret negative sexual events according to an incompetence self-schema. Furthermore, women with sexual dysfunction are more likely to endorse age-related and body image beliefs such as "the pleasure in sex decreases as women age" and "after menopause, women cannot reach orgasm." Interestingly, their data showed that women holding more conservative sexual beliefs were more likely to have sexual desire disorder problems but such beliefs were not predictive of FOD. Consequently, we are left with no "smoking guns" regarding a specific nonmedical contribution to FOD, but we can certainly conclude that for any women experiencing FOD, performance anxiety and interfering thoughts play a significant role.

CASE EXAMPLE: FEMALE ORGASMIC DISORDER

Jan, age 25, stated that she and her 30-year-old boyfriend, Bob, have been together for 7 years and she was coming to therapy because of conflicts over their sexual relationship. She identified two problems that were standing in the way of finalizing marriage plans: (1) there was a desire discrepancy

with Bob, who desired sex several times a week, and Jan, who desired sex about once every 2 weeks; and (2) Jan had never experienced orgasm either through sexual relations with a partner or through masturbation. Jan and Bob were each interviewed separately and both expressed very positive feelings for each other. Jan stated that once involved sexually, she enjoyed her sexual experience which she described as a rise in sexual excitation but then "hitting a plateau" and never having a specific release or rhythmic muscle contractions. She was mostly satisfied with her sexual experiences but had become increasingly worried because Bob was very focused on her orgasm and tended to become self-critical because of her lack of orgasm.

Jan was raised in a loving but very rigid middle-class family. Her parents showed very little physical affection and they never discussed sex with either Jan or her two older sisters. Jan said that it was a very "stiff" and somewhat formal family environment and she never felt comfortable talking about any personal topics and especially about sex. Jan was attractive but a bit overweight and felt self-conscious and dated infrequently before meeting Bob. She had one previous sexual experience, which she described as pleasant. She graduated from college and was currently employed full time. Jan was physically healthy and on no medications. She denied any substance abuse problems and had no mental health history although she described herself as having "adult ADD" and "difficulty getting in the right mood."

Bob was also raised in a middle-class family but, unlike Jan's family, his parents were more open in their expression of affection and sexual matters. Bob's mother, however, was a very anxious person and Bob tended to also be very anxious and had fears of travel and especially of driving over bridges. He had numerous sexual experiences before meeting Jan and had found that sex was a way for him to relieve his anxiety. He described sex as being very important and he was very aware that he tended to put a lot of pressure on Jan for sex and he tended to evaluate the intensity of each sexual experience. Bob was working part-time and was also attending college part time to complete his degree.

Jan and Bob described their lives as very busy with little time for pleasure. They rarely went out alone as a couple and on those occasions when they did socialize, it was with other couples. Both described themselves as being fatigued much of the time.

Comment

Jan was most concerned about her lack of orgasm because of the importance attached to it by Bob. Bob, in fact, identified Jan's lack of orgasm and Jan's lower desire level as contributing to his hesitancy and doubts about marriage. Jan enjoyed sex but was certainly experiencing a great deal of

performance anxiety due to Bob's urgency and evaluative nature related to sex. Separate from Bob's influence, Jan also had difficulty setting aside time for pleasure and staying focused. During private masturbation she found that her mind wandered after a short time and that pleasant sensations vanished. She nonetheless would persist in self-stimulation in spite of the absence of pleasant erotic imagery or pleasant sensations.

The important therapy focus for Jan and Bob was to help them to redefine sexual success more broadly and view orgasm as a possible by-product of a sexual exchange but not a necessity. The purpose of this focus was to reduce the performance anxiety and reinforce positive sexual experiences. A second focus of therapy was to help both Jan and Bob enjoy pleasurable activities without feeling that they were taking away from their work and other responsibilities. This effort included prioritizing "pleasurable/fun time" for the couple and also included private time for Jan for self-stimulation. It was emphasized that her private time should be planned and occur only when she was able to be relaxed and stay focused. Rather than focusing on orgasm as the goal, the goal was to help Jan to stay focused on positive sexual imagery and positive sensations. She was also encouraged to explore various approaches to self-stimulation including the use of vibratory stimulation. The balance that was being orchestrated in this approach was to help build sexual skills without a performance orientation. This approach proved to be very helpful for the couple and it immediately reduced stress for both. Jan eventually was able to achieve orgasm during self-stimulation. Orgasm was also achieved through oral and manual genital stimulation during interactive sex.

4

Delayed Ejaculation

DESCRIPTION AND CLINICAL PRESENTATION

The term "ejaculatory disorders" is a catch-all term that includes disorders in emission, ejaculation, and orgasm (Jannini & Lenzi, 2005). For most males most of the time, emission, ejaculation, and orgasm are experienced as one event that includes involuntary rhythmic pelvic muscle contractions, intense pleasure, genital sensations, and expulsion of semen. Consequently, it is common for the terms "ejaculation" and "orgasm" to be used interchangeably. In actuality, however, the term *emission* refers to the secretion of seminal fluid in the male genital tract, while *ejaculation* refers to the expulsion of semen from the urethra, and *orgasm* generally refers to the intense subjective pleasure and genital sensations that are accompanied by rhythmic muscle contractions. To add to this already complex picture, it is possible to have ejaculation without the expulsion of sperm (retrograde ejaculation) and without orgasm (anaesthetic ejaculation) and it is also possible to have orgasm without ejaculation. Finally, ejaculation may be experienced with varying amounts of ejaculate and orgasm may be experienced with varying degrees of intensity from barely perceptible to "rockets" and an altered state of consciousness.

Most men and women are unaware of the above facts and may harbor misunderstandings and unrealistic expectations regarding the male ejaculation/orgasmic experience. Often, patients will present with concerns about the absence of coital, multiple, or simultaneous orgasms; they feel disappointed that they cannot achieve what "everyone else" enjoys, and they seek a cure for their "deficits." Male patients have presented to us their concerns about "premature ejaculation" when, in fact, they are exceeding all textbook definitions. One male patient stated that he has never had a problem bringing any female partner to orgasm through intercourse, that he usually lasted 5–10 or more minutes with vigorous thrusting, and often

has multiple intercourse experiences during sexual episodes. Still, he felt he had a "premature ejaculation" problem because he would ejaculate before he wanted to on some occasions and "guys in the porno movies could hold it to the exact moment they wanted, no matter how intense the sex was." As will be discussed in the treatment chapters, such patients often benefit from some gently delivered education, supplemented with normative data and reassurance regarding their sexual health. In this chapter, we are discussing *delayed ejaculation*, which is the other end of the continuum from *premature (early) ejaculation*.

The terms "blue balls," "dry runs," "aspermatism," "anejaculation," "ejaculatory incompetence," "retarded ejaculation," "absence of ejaculation," "ejaculatory impotence," "ejaculatory inhibition," "inhibited male orgasm," "ejaculation retardate," "impotentia ejaculandi," and "male orgasmic disorder" have all been used to describe the problem some men have in ejaculating and in reaching orgasm. Rather than refer to such patients' difficulty as "retarded," "incompetent," "impotent," or "inhibited," all of which have either a pejorative or a theoretical slant, the new DSM-5 uses the term "delayed ejaculation." In an exhaustive Medline search, Segraves (2010) found a relatively infrequent usage of the term "orgasm" as opposed to terminology specifying ejaculation for male disorders. Segraves (2010) suggested the name change to "delayed ejaculation" "for the official diagnostic nomenclature to be congruent with current usage" (p. 691).

Delayed ejaculation refers to the persistent difficulty or inability to achieve orgasm despite the (apparent) presence of adequate desire, arousal, and stimulation. Most commonly, however, the term refers to a condition in which a man is not able to ejaculate with his partner, even though he is able to achieve and maintain an erection. Importantly, the man is typically able to ejaculate during masturbation or sleep (nocturnal emissions, or "wet dreams"). Like other sexual dysfunctions, delayed ejaculation can be lifelong or acquired, and generalized or specific. Although rare, there are also some men who have never experienced ejaculation or orgasm under any circumstances (nocturnal emission, masturbation, or during partner genital stimulation).

It is important to distinguish between "delayed ejaculation" and "retrograde ejaculation." The latter difficulty occurs as a result of some medications (e.g., anticholinergic drugs), after some (but not all) prostate surgeries, and occasionally as a consequence of diabetic neuropathy. With retrograde ejaculation, a man does ejaculate and experience orgasm, but the ejaculatory fluid travels backward (into the bladder) rather than forward and out the urethra. The sensation of orgasm is preserved for most men who experience retrograde ejaculation, although some do report a slight diminution in pleasurable sensation.

It is also important to distinguish between emission and ejaculation.

Ejaculation has three stages: (1) emission, (2) bladder neck closure, and (3) ejaculation proper (Segraves et al., 1985). Emission refers to the release of the ejaculate into the pelvic urethra; this release is caused by the contraction of the vas deferens, seminal vesicles, and smooth muscle of the prostate. Bladder neck closure prevents retrograde ejaculation. Finally, ejaculation proper results from contractions of the bulbocavernosus, ischiocavernosus, and urethral muscles (Segraves et al., 1985). Refer to the diagnostic criteria for delayed ejaculation (302.74) as presented in DSM-5 (American Psychiatric Association, 2013).

Marked *delay* in ejaculation begs the question "Exactly what is the normal or usual amount of time for ejaculation?" Unfortunately, we have very few well-controlled studies that answer this question. One exception is the research by Waldinger and Schweitzer (2005) in which a total of 500 heterosexual couples were recruited from five countries and intravaginal ejaculation latency time (IELT) was measured using a stopwatch rather than a retrospective questionnaire. Across all countries, the median IELT was 5.4 minutes; the mean IELT was about 8 minutes; and the standard deviation was 7.1 minutes. DSM-5 does not use these data or other objective measures of latency but rather uses the subjective criteria of whether or not the individual desires delay and whether or not the individual is notably disturbed or impaired by the problem. Because of the use of subjective criteria, it is difficult to derive exact numbers regarding prevalence.

Although no data are available, our clinical impression is that men who experience delayed ejaculation express greater upset than women who experience problems with orgasm. The reason for this may be because men (and their partners) expect ejaculation to occur 100% of the time they engage in sexual behavior, whereas women's expectations allow for a wider variety of outcomes. Thus, the lack of ejaculation, in spite of adequate erotic stimulation, is more likely to be distressing. This is especially true in the cases of heterosexual couples who are trying to become pregnant.

PREVALENCE

Delayed ejaculation is relatively rare. Studies from the late 1970s provided population estimates that ranged from 4–10% (Frank et al., 1978; Nettelbladt & Uddenberg, 1979), while population estimates completed in the 1990s have tended to be lower, ranging from 0% (Schiavi, Stimmel, Mandeli, & White, 1995) to 3% across six studies (Fugl-Meyer & Sjogren Fugl-Meyer, 1999; Lindal & Stefansson, 1993; Singer, Weiner, & Sanchez-Ramos, 1992; Solstad & Hertoft, 1993; Ventegodt, 1998). An exception to these rates is the 8% rate reported by Laumann, Paik, and Rosen (1999).

Older studies from sex therapy settings report that delayed ejaculation

(reported as male orgasmic disorder) may be the dysfunction least often encountered. Masters and Johnson (1970) reported only 17 cases of male orgasmic disorder out of 448 male sexual dysfunction cases they assessed and treated in an 11-year period. Kaplan (1974) stated that her sample size was too insignificant to report. Other clinical studies suggest that the dysfunction accounts for 3–8% of the cases presenting for treatment (Bancroft & Coles, 1976; Frank, Anderson, & Kupfer, 1976; Hawton, 1982; Renshaw, 1988). More recent studies support delayed ejaculation as a rare occurrence and estimate that no more than 3% of men complaining of sexual dysfunction identify delayed ejaculation as a problem (Christensen et al., 2011; Perelman & Rowland, 2006; Waldinger & Schweitzer, 2005).

As this literature review suggests, estimates have ranged widely. It is clear that there have been many methodological differences across these studies, especially involving sampling (e.g., HIV-infected vs. healthy samples) and, most importantly, the definition of the disorder (Simons & Carey, 2001). There has been little agreement regarding whether the delayed or absent orgasm was a single occurrence. Rarely have investigators reported whether the men studied can experience orgasm through masturbation.

ETIOLOGY

Biological Factors

More recent theories regarding factors effecting ejaculation latency posit that IELT is on a neurobiological continuum with premature (early) ejaculation on one end and delayed ejaculation on the other end (Waldinger & Schwitzer, 2005). While the exact mechanism of action is unknown, some researchers have focused on serotonin (5-HT) receptor sensitivity in the ejaculatory modulating center of the central nervous system (CNS) as the main area of interest (Preda & Bienenfeld, 2013; Waldinger & Schwitzer, 2005). Consistent with the continuum theory of ejaculation latency is the statistical reality that a small percentage of men will fall on one end of the continuum and have lifelong premature ejaculation while a small percentage of men will fall on the other end of the continuum and have lifelong delayed ejaculation unrelated to any external factors and through no fault of their own other than their genetic makeup. In addition to this baseline reality there are other biological factors to consider that may also impact ejaculation latency.

Biological factors related to delayed ejaculation may be of an acute nature and easily reversible such as those related to acute substance abuse or pharmacological agents, as well as those related to certain infections such as prostate infection or urinary tract infection. Most commonly, we see patients who are being treated for anxiety or depression with SSRIs

complaining of delayed ejaculation; however, many other pharmacological agents also contribute to this problem (Yang & Donatucci, 2006). Delayed ejaculation is also found in many chronic medical conditions such as spinal cord injury, multiple sclerosis, severe diabetes, and abdominoperineal surgery (Perelman & Rowland, 2006; Preda & Bienenfeld, 2013; Waldinger & Schweitzer, 2005).

A number of studies have identified delayed ejaculation to be at least moderately related to age, with older males more susceptible (Perelman & Rowland, 2006; Preda & Bienenfeld, 2013; Waldinger & Schweitzer, 2005). Preda and Bienenfeld (2013) point out that men in their 80s report twice as much difficulty ejaculating as men younger than 59. The reduction of testosterone in aging men and loss of peripheral sensory nerve conduction may be contributing factors (Preda & Bienenfeld, 2013).

Psychosocial Factors

At the psychological level of analysis, the possible etiologies that have been identified include fear (of castration, pregnancy, or commitment), performance anxiety and "spectatoring," strict religious proscriptions leading to guilt or avoidance, previous sexual traumas, and hostility (toward one's partner or oneself) (Perelman & Rowland, 2006; Waldinger & Schwitzer, 2005). "Spectatoring" is a term commonly used to describe the phenomenon of focusing on one's performance rather than on enjoying the process and moment of sex. Thus, it appears that there may be many pathways to male orgasmic disorder. Indeed, after reviewing the psychosocial literature, Shull and Sprenkle (1980) concluded: "If the literature is searched long enough, almost any and every psychological problem can be associated with [male orgasmic disorder]" (p. 230). Despite the richness of these clinical hypotheses, virtually no systematic research has been conducted on the individual or relationship factors described earlier.

Relationship factors have also been implicated in male orgasmic disorder. A man may be ambivalent about his commitment to the relationship, or he may be anorgasmic as a way of assuming power in a troubled relationship. Shull and Sprenkle (1980) suggest that a simpler relationship problem may also be common, namely, inadequate stimulation. They suggest that the partners may not have created the proper ambience, are using inadequate stimulation techniques, or are engaged in sexual behavior that has lost its erotic impact.

Perelman (2005) points out that idiosyncratic masturbation styles may also be a contributing factor to delayed ejaculation. Idiosyncratic masturbation is any technique that a male may reliably use during solo masturbation to achieve orgasm that is not readily duplicated by his partner's hand, mouth, anus, or vagina. We have encountered many men presenting with

delayed ejaculation who fit this profile. Some examples are (1) a man who squeezes the head of his penis in order to orgasm; (2) a man who rubs his penis against an object such as a pillow in order to orgasm; (3) a man who vigorously rolls his penis between the palms of his hands in order to orgasm (picture a boy scout twirling a stick between his hands to make a fire); and (4) a man who places his penis in a vise-like device in order to orgasm. These are just some of the many examples we have encountered in men who have presented with the complaint of delayed ejaculation.

Finally, there should also be consideration of men who are only aroused by certain fetish objects or behavior. For example, one of our patients is able to ejaculate with his wife during intercourse if she is bound in rope. Without the bondage, he is unable to ejaculate even though he reports he finds the intercourse pleasant.

CASE EXAMPLE: DELAYED EJACULATION

Phil is a 39-year-old engineer with a graduate degree who presented to the clinic with a complaint of an inability to achieve intravaginal ejaculation. He and Linda, age 36, have been married 3 years and in a first marriage for both of them. They have a 1-year-old daughter who was conceived by intrauterine insemination (IUI). This procedure, which occurred in their fertility doctor's office, involved Phil providing a sperm sample and then introducing his sperm by catheter into Linda's uterus. Although both Phil and Linda were pleased with the pregnancy and birth of their daughter, they very much wanted to "conceive naturally" by intercourse for their second child.

Phil reported a lifetime history of an inability to ejaculate intravaginally. Several important factors emerged in Phil's history that may have contributed to this problem. He stated that he found Linda very attractive and they were very loving and compatible and he very much enjoyed Linda's approach to sex. However, he recalled that he always felt guilty about having an orgasm with any woman because he was raised without a father and he felt he was the man of the house to his mother and two younger sisters. The message of protection and respect for women was strongly inculcated in his upbringing and seemed to translate into sexual inhibition. In addition, he revealed that he had always masturbated to orgasm by pressing the head of his penis between his thumb and two forefingers while imaging having sex with an older heavier woman.

Apparently, this imagery and style of masturbation began in childhood and was associated with a heavy-set babysitter of whom he was very fond. While he remembered no direct sexual contact with his babysitter, he did remember her physical affection and closeness. Finally, Phil also reported a history of depression for which he had been taking Effexor for a number

of years. His problem with delayed ejaculation predated his use of Effexor but the Effexor may have exacerbated his problem. His depression and general worry recently increased when he and Linda moved across country for Phil's new job, leaving behind family and friends.

During sexual activity with Linda, Phil was always able to obtain and maintain an erection throughout foreplay and intromission. Sexual intercourse would end after 10 or 15 minutes of thrusting without ejaculation. Phil always found sex pleasant and Linda usually achieved orgasm but because of the desire for a "natural pregnancy," Phil and Linda were expressing increased frustration and Phil was experiencing performance anxiety.

Comment

This case illustrates a common challenge to therapists dealing with a sexual problem that may be etiologically rooted in a combination of plausible explanations. In Phil's case, there are three strong possibilities.

1. The strong influences of his upbringing that attached shame and guilt to intravaginal ejaculation with women. Although he was able to intellectually challenge this notion, he nonetheless felt sexually inhibited by this history. This same dilemma is sometimes experienced by individuals raised in a strong sexually condemning religious environment. Dismissing childhood religious beliefs as an adult doesn't necessarily relieve one of deep-seated religious-born sexual guilt. In spite of the tenacious nature of such developmentally implanted sexual beliefs, it is worthwhile to proceed with cognitive restructuring around this issue. Phil's intellectual understanding of the negative influence on his sexual development provided a gateway to addressing this issue.

2. The second likely influence on Phil's delayed ejaculation is his unorthodox masturbatory practice. Perlman (2005) points out that an idiosyncratic masturbatory practice can inhibit intravaginal orgasm. Phil repeatedly engaged in masturbation throughout his life by squeezing the head of his penis and fantasizing about having sex with a heavy-set older woman. This masturbatory practice may have conditioned Phil to sexually respond to similar tactile sensations and fantasy associations. Vaginal sexual intercourse with thrusting may not have duplicated the necessary sensations he had been conditioned to during masturbation.

Patients presenting with delayed ejaculation and idiosyncratic masturbatory practices are instructed to use a lubricant and to practice masturbation with a stroking motion. This combination is more likely to duplicate the sensations experienced during vaginal intercourse in heterosexual rela-

tionships or anal intercourse in male homosexual relationships. Patients are encouraged to focus on their most arousing erotic imagery and they are also told to expect that orgasm/ejaculation may take many trials before achieving the desired outcome. This instruction helps to mitigate performance anxiety.

3. The third likely contributor to delayed ejaculation was Phil's depression and use of the SSRI Effexor. While delayed ejaculation preceded these elements, depression and SSRI medication increase the weight of the other two factors identified above. Addressing depression and orgasmic-inhibiting medication is certainly an important part of any treatment program for delayed ejaculation. In some cases, the depression may be so severe that it must be addressed and diminished before treatment of delayed ejaculation can begin. In Phil's case, the increase in his depression was related to his recent move and feelings of displacement and was not of significant magnitude to delay addressing delayed ejaculation directly with cognitive restructuring and a new masturbatory practice.

Finally, it was important to inform Linda and include her in the treatment protocol for Phil. In most cases, a partner's understanding of the etiology and treatment protocol will reduce performance anxiety and cultivate a cooperative effort.

5

Premature (Early) Ejaculation

DESCRIPTION AND CLINICAL PRESENTATION

Premature (early) ejaculation was described in medical books almost 100 years ago as "premature ejaculation" (a condition in which a man ejaculates just before vaginal penetration) and as "rapid ejaculation" (a condition in which a man ejaculates immediately after vaginal penetration) (Huhner, 1917). These terms have remained with us to the present time but our understanding of the mechanism of action of this phenomenon has been greatly advanced. Huhner (1917) proclaimed that premature and rapid ejaculations were caused by repeated coitus interruptus, which led to distended seminal vesicles and hypersensitivity of the penis. His conclusions were, of course, based entirely on conjecture and not on systematic research studies. More recent psychopharmacological studies have led to the hypothesis that early ejaculation is a "neurobiological dysfunction related to a disturbance in central serotonin neurotransmission and 5-HT postsynaptic receptor functioning" (Waldinger, 2007, p. 563).

In addition to having a better understanding today of the neurobiology of premature (early) ejaculation, we also have a much more comprehensive description of the phenomenon. DSM-IV-TR used the term "premature ejaculation" and, as noted above, this term was used almost 100 years ago. An impetus for changing the name "premature ejaculation" and its diagnostic criteria came from the work proffered by the subworkgroup committee on the sexual dysfunctions in preparation of DSM-5 chaired by Taylor Seagraves (Binik, Brotto, Graham, & Segraves, 2010). This workgroup noted the tremendous amount of knowledge gained since the original DSM-IV description and criteria were established. They also noted criticism of the existing name (that some saw as pejorative) and the existing criteria on multiple grounds including the lack of precision and challenges with new research findings (Althof et al., 2010; Binik et al., 2010; Segraves,

2010). In the end, the DSM-5 editors decided to use the term "premature" with the added term "early" in parentheses. The DSM-5 diagnostic criteria are believed to be much more precise and reflective of and substantiated by research studies. Refer to the diagnostic criteria for premature (early) ejaculation (302.75) as presented in DSM-5 (American Psychiatric Association, 2013).

In addition to the two subtypes (lifelong and acquired) identified in DSM-5, Waldinger has proposed two additional subtypes that he labeled "natural variable premature ejaculation" and "premature-like ejaculatory dysfunction" (Waldinger & Schweitzer, 2006; Waldinger, 2007). Waldinger (2007) describes "natural variable premature ejaculation" as a normal variation in sexual performance during which early ejaculation occurs inconsistently and a man's ability to withhold ejaculation is diminished or lacking. Moreover, this complaint relates to situational problems and is reversible. In "premature-like ejaculatory dysfunction" a man's actual ejaculatory response time is in the statistically normal range (ejaculation 1–10 minutes following anal or vaginal penetration) but psychological and/or relationship factors lead him to feel there is a problem. Importantly, neither we, nor Waldinger (2007), view either of these subtypes as pathological states. Thus, we are not recommending that they be viewed as sexual dysfunctions. Rather, we mention them here because these categories have a high prevalence rate and most likely account for the majority of cases that present to treatment clinics with complaints of premature (early) ejaculation. As Waldinger (2007) suggests, in our clinic, we have found that these cases in which a man has only variable, inconsistent premature (early) ejaculation, or has the belief he has premature (early) ejaculation despite a normative ejaculatory response time, are among the most common presentations. Further, they are often associated with a great deal of distress and can benefit greatly from treatment including the provision of normative information, psychoeducation, and cognitive strategies as needed. The distress associated with premature (early) ejaculation often stems from the belief that men should be able to control the timing of their ejaculation and that failure to do so is purposeful and a sign of inadequacy or selfishness. The added misbelief that the normal length of time for intercourse exceeds 15 minutes or more compounds the distress felt by a man and his partner. The source of misinformation often comes from the observation of the performance of pornographic actors or from the boasting of friends. Regardless of the source, the misbelief and false expectations can lead to tears and threats of terminating the relationship. Performance anxiety is often spawned as stress increases over premature (early) ejaculation and attention is focused on the length of time of intercourse before ejaculation occurs. The performance anxiety can subsequently lead to ED and avoidance of sex altogether.

The criteria used to define premature (early) ejaculation have varied considerably and have included various definitions over the years. Masters and Johnson (1970) suggested that premature ejaculation be diagnosed when a man "cannot control his ejaculatory process for a sufficient length of time during intravaginal containment to satisfy his partner in at least 50 percent of their coital connections" (p. 92). The problem with this definition is that a large percentage of women cannot reach orgasm through intercourse regardless of how long it lasts! It also inaccurately assumes that this problem occurs only in heterosexuals.

It is very clear that a universally accepted definition of premature (early) ejaculation has not been agreed upon. In a review of the literature, Metz, Pryor, Nesvacil, Abuzzahab, and Koznar (1997) point out that the time to ejaculation after penetration is not a useful criterion for defining premature ejaculation because this time varies from 1 minute to 10 minutes in published studies. DSM-IV-TR avoided using objective criteria and relied on clinical judgment to make the determination.

In addition to the differences of opinion regarding definition, another debate involves whether premature ejaculation should even be considered a dysfunction. As noted by Kinsey, Pomeroy, and Martin (1948), the majority of mammals ejaculate at intromission or shortly thereafter. Interviews conducted by Kinsey's group indicated that 75% of their sample of over 6,000 men ejaculated within 2 minutes of vaginal containment. On the basis of these two sources of information, Kinsey and his colleagues went on to suggest that from an evolutionary perspective, such a quick and intense ejaculatory response was probably adaptive and, in this sense, "superior." A similar position was argued by Hong (1984), who, after reviewing the literature, concluded that "premature ejaculation by itself should not be of clinical concern unless it is extreme, such as occurring before intromission" (p. 120). To those who might ask about the partner's pleasure, Hong went on to say that "sexual fulfillment in women can be achieved by other and perhaps better means." Although this definition is heterosexist, the key point is that premature (early) ejaculation may be seen as "adaptive" in a certain sense; thus, we need to be cautious about calling it a dysfunction.

Most recently, the definition of premature (early) ejaculation is based on intravaginal ejaculation latency time or IELT. IELT is the time between vaginal intromission and intravaginal ejaculation and has been measured by "stopwatch" studies (Waldinger & Schweitzer, 2005).

These debates notwithstanding, many men are troubled by premature (early) ejaculation, and this difficulty can have a destructive effect on a man, his partner, and their relationship. Kaplan (1979) suggests that men with premature ejaculation are at risk for developing a general sense of inadequacy and failure, depression, and other sexual dysfunctions (e.g., desire and erection difficulties). Some men may not understand why they

experience premature ejaculation and make inappropriate inferences about their difficulty, such as "I must really be selfish."

Although most people enjoy foreplay and direct stimulation of the clitoris or penis, others believe that stimulation during intercourse is "better," or that penetration is the only acceptable form of sexual activity. When a man has difficulty with ejaculatory latency, a partner who overvalues intercourse may be disappointed by, and may lose interest in, sex. Partners can also make inappropriate inferences about the cause of early ejaculation (e.g., "I must not be very attractive if he wants to get it over so quickly" or "He does not love me"). It is not difficult to see how such outcomes, especially if combined with other expectations and concerns, can have undesirable effects on a relationship.

Yet another side effect of premature (early) ejaculation is that a man may try to prolong his "staying power" by any of several home remedies. Some may try to postpone orgasm by holding back, physically or emotionally. Others will try to distract themselves from their pleasurable sensations by thinking of financial concerns or other difficulties. A few may attempt to decrease sensations by using multiple condoms or thinking nonsexual thoughts. These "solutions" may have iatrogenic effects and may also lead to erectile problems. Overall, premature (early) ejaculation can have far-reaching and negative consequences.

PREVALENCE

Varying prevalence rates for premature (early) ejaculation are reported in the literature. This variation reflects the lack of a universal definition of premature (early) ejaculation and also reflects the myriad of experimental designs and populations present in published research studies. Masters and Johnson (1970) identified premature (early) ejaculation as one of the most common male sexual dysfunctions. Indeed, prevalence rates as high as 30% have been reported when patient self-report is used as the measure of premature (early) ejaculation. When stricter definitions of premature (early) ejaculation are used (such as IELT) and more rigorous measurements are used (such as stopwatch measures), the prevalence rate drops dramatically to about 1–3% (Althof et al., 2010). The inflated premature (early) ejaculation prevalence rates reflected in self-report measurement are due to the inclusion of men who present with intermittent premature (early) ejaculation and men with misunderstandings of premature (early) ejaculation who are actually functioning in a statistically normal range and do not meet DSM-5 criteria. Whether a man presenting with premature (early) ejaculation meets diagnostic criteria or not, both he and/or his partner may express considerable distress.

ETIOLOGY

Biological Factors

Since the work of Masters and Johnson (1970) and up to the late 1980s, premature (early) ejaculation was largely assumed to be caused by psychological factors such as anxiety. The absence of any viable explanatory biological evidence for premature (early) ejaculation added to the impression of psychological causation. Beginning in the late 1980s, however, various researchers have presented possible biological explanations that go far beyond the speculation of early sexologists in the field. Differences in the cortical evoked potential of men with true premature (early) ejaculation (Fanciullacci, Colpi, & Beretta, 1988) and disturbances in central serotonergic neurotransmission (Waldinger et al., 1998) are two new hypotheses. The latter focus of inquiry was inspired by the impact of SSRIs on ejaculatory function. A common side effect for men taking SSRIs is a delay in ejaculation and, in fact, SSRI medication is commonly used "off label" to treat premature (early) ejaculation. Consequently, it is hypothesized that abnormalities in the serotonin receptors result in some men having a lower threshold for sexual stimulation, resulting in quicker ejaculation. For men presenting with acquired premature (early) ejaculation, chronic bacterial prostatitis has been suspected (Shamloul & el-Nashaar, 2006). Biological theories of lifelong and acquired premature (early) ejaculation have compelled a strong move away from purely psychological theories.

Psychological Factors

In light of the increasing possibility of biological explanations for premature (early) ejaculation, psychosocial theories today seem less compelling. In addition, there have not been any well-controlled studies supporting psychological causation and data that does exist may be correlational. Althof et al. (2010) point out that while many psychological factors have been identified in association with premature (early) ejaculation, such as sexual abuse, negative sexual attitudes, depression, poor body image, and performance anxiety, none are viable explanations. Furthermore, it is possible that some factors, such as performance anxiety, may have a reciprocal relationship with premature (early) ejaculation. Performance anxiety may lead to premature (early) ejaculation and, once established, premature (early) ejaculation will increase performance anxiety (Althof et al., 2010). Of clinical note, when men and their partners are informed that premature (early) ejaculation may be biologically determined, there is often great relief and a lessening of blame and distress. The reason for this is that premature (early) ejaculation has often been thought of as a weakness and contrary to "staying power"; consequently, if it is biological, it is not a personality weakness.

CASE EXAMPLE: PREMATURE (EARLY) EJACULATION CONTRIBUTING TO ERECTILE DYSFUNCTION

Bill, age 42, was referred to the Men's Health Center by his primary care physician for treatment of ED that had been present for 1 year. He reported that he had been in a very satisfying relationship with Mary, age 39, for the past year and a half. Mary lived alone in her own home and had been previously married and divorced. Bill also had been previously married, was divorced 7 years ago, and was now living with his brother. Bill had two daughters (ages 10 and 18) from his marriage. Every other weekend, Bill's daughters would stay with him and on those weekends Mary would not stay overnight. Bill and Mary would occasionally sleep together during the week, but most often sexual opportunities would be every other weekend when Bill did not have his children.

Bill reported a history of hypertension and hyperlipidemia and had been recently found to have low normal total testosterone levels. Mary had no medical problems and neither Bill nor Mary reported a history of mental health or substance abuse problems. In the intake interview, Bill recounted that throughout his sexual life he had experienced an IELT of about 1 minute or less. With his wife and other previous partners, this was never identified as a problem and Bill never thought much about it. Mary was the first sexual partner to bring it to his attention and label it premature ejaculation. At times, Mary would become upset with Bill because of his early ejaculation and she questioned whether or not he found her attractive. This is ironical since, if anything, the opposite conclusion might have been drawn, with one typically concluding that early ejaculation was associated with hyperarousal rather than the lack of arousal. Nonetheless, the impact of such statements led to hypervigilance and ED and then sexual avoidance. Mary then urged Bill to seek help for "his problem."

Comment

Bill's experience of ED was most likely a sequela of focused attention on premature (early) ejaculation. An explanation of performance anxiety was presented to Bill and he responded by noting that both he and Mary were insecure and tended to be performance-oriented. Bill was an amateur musician and readily understood the concept of performance anxiety, which he had experienced on occasion when playing before what he perceived to be a sophisticated musical audience. He was able to grasp how performance anxiety affected his sexual relations with Mary since he was able to achieve full erections during solo masturbation and during sleep. Once the concept of performance anxiety was explained to both Mary and Bill and an emphasis was placed on pleasure and intimacy rather than control,

they were able to remove blame and resume sexual activity. In addition, IELT was explained as a largely biological phenomenon and, if anything, was a reflection of attraction and arousal. Subsequently, premature (early) ejaculation diminished as a concern.

One additional factor in this case was that opportunities for sexual relations were limited because of the couple's schedule and living arrangements. Consequently, the pressure to be sexual when they were together was increased. This arrangement exacerbated the performance anxiety and both Mary and Bill felt the need to take advantage of the sexual opportunity even if one or the other was not in the mood.

6

Female Sexual Interest/Arousal Disorder

DESCRIPTION AND CLINICAL PRESENTATION

Sexual interest refers to an individual's desire or drive to engage in sexual activity. *Sexual arousal* has been defined differently over time. In DSM-IV-TR (American Psychiatric Association, 2000) noted that arousal referred specifically to the body's response to sexual excitement. In women, it referred to vasocongestion, vaginal lubrication, and swelling of external genitalia. Others (Bancroft, 2005; Graham & Bancroft, 2009) have taken a broader view of arousal and argued that in addition to genital arousal, sexual arousal is a state that also includes motivation toward sexual pleasure, attentional focus on sexually relevant information, and general arousal.

In the past, sexual interest and sexual arousal have been thought of as separate, though linked processes, for both men and women. This is in part due to the fact that since the third edition of the DSM (DSM-III; American Psychiatric Association, 1980), the nomenclature has been based largely on Masters and Johnson's sexual response cycle (1966, 1970) and addition of desire as a first phase of this cycle (Kaplan, 1979). That is, the sexual response cycle was proposed to consist of three distinct phases; desire, arousal, and orgasm. The DSM classification system mapped onto these phases. Thus, most recently, DSM-IV-TR included separate diagnostic categories of hypoactive sexual desire disorder (HSDD) and female sexual arousal disorder (FSAD). HSDD was defined by the absence of sexual fantasies and a lack of desire for sexual activity associated with distress. The key feature of FSAD was continuous or recurrent inability to retain, or maintain, sufficient lubrication–swelling response.

Chapters 2 and 7 of this book further describe these disorders in men. In simplest terms, for men, interest or desire is what happens in the mind, and arousal or erections are what occur in the body, including the penis. This nomenclature and mind/body split has proved more controversial in

women, however. As a result of recent findings and longer term academic discussions (e.g., Tiefer, Hall, & Tavris, 2002), DSM-5 now addresses these problems in a different manner for women than it does for men. Whereas male arousal and desire problems remain as separate diagnoses (see Chapters 2 and 7), these domains of sexual functioning have been combined for women, in a newly titled diagnostic category, "female sexual interest/arousal disorder" (American Psychiatric Association, 2013).

No other area of sexual functioning nomenclature has been so dramatically changed. Relatedly, it is likely that no other sexual-functioning diagnostic categories have been so heatedly debated since the last edition of this book (e.g, see Binik et al., 2010). In the end, it was decided to combine these previously separate diagnoses, as the DSM-5 workgroup argued that desire and arousal could not be reliably distinguished and that, when viewing their own sexuality, women do not distinguish these as separate processes (Brotto, Heiman, & Tolman, 2009; Grahan et al., 2004). For example, a number of published studies have reported high correlations between sexual desire and sexual arousal domains on a commonly used female sexual functioning assessment measure, the Female Sexual Function Index (FSFI; Rosen et al., 2000). Across samples of women, these domains have been correlated at between 0.52 and 0.85 (Brotto, 2010), demonstrating considerable overlap between desire and arousal in women. However, it is notable that a correlation of 0.52, while indicating substantial overlap, also indicates some uniqueness of these domains.

Whether viewed as separate processes or within more of a mind–body dualistic approach, many individuals have considerable uncertainty about female interest and arousal. Cultural norms have changed greatly in this area over the last century, perhaps leading to ongoing confusion. Whereas it was once considered normative that women did not have sexual desires and fantasies, and that sex was something to be endured for the sake of procreation or pleasing a male partner, current misconceptions can now often mirror those of men, specifically, that a woman should *always* be interested in sex and should *always* find sex arousing. The blending of these two views within society can be difficult and female patients often present with these areas of confusion. One patient reported that she was raised to believe that "nice girls" didn't think about or enjoy sex. When she found herself daydreaming about sex during college classes or experiencing vaginal lubrication during sexual encounters, she felt ashamed. Years later, she presented in our office because she had found that she was only interested in sexual activity when certain conditions were met (e.g., her children were soundly sleeping or out of the house, she had sufficient time to relax after work) and she was frequently refusing her husband's attempts to initiate sex. The frequency of sexual activity had fallen off to approximately once every 2–4 weeks, and the couple were quite concerned about her low sex-

ual interest. This patient reported feeling "damned if I do, and damned if I don't." Finding her own voice in sex, rather than simply hearing her mother's warnings or her husband's requests, was an important goal of treatment.

Female sexual interest/arousal disorder is diagnosed in the persistent absence or notable reduction of mental interest in sex and/or physical responsiveness to sexual cues. As the diagnosis requires that a woman have at least three of six different symptoms, the disorder can take a number of different forms. In fact, two women diagnosed with this same disorder may present with fairly different symptom profiles. For one woman, this could look primarily like an absence of sexual fantasies, thoughts of sex, and desire to engage in sex, but she might find her body sexually responsive and that she is able to experience sexual pleasure on the occasions on which sexual activity does occur. For another woman, this disorder could be predominantly defined by a lack of bodily response and pleasurable sensations. Refer to the diagnostic criteria for female sexual interest/arousal disorder (302.72) in DSM-5 (American Psychiatric Association, 2013).

Of note, these symptoms must persist for at least 6 months as transient changes in sexual interest and desire, in response to stressors and life circumstances, are normative. Additionally, though the criteria has attempted to operationalize reduced arousal, specifying that it must occur in 75–100% of all sexual encounters (Criteria A4 and A6), there is still a need for considerable clinical judgment. With age, women may normatively experience reduced sexual thoughts and fantasies (Bancroft, Loftus, & Long, 2003c; Johannes & Avis, 1997; Purifoy, Grodsky, & Giambra, 1992) and the most apparent physical sign of sexual arousal, vaginal lubrication, decreases significantly postmenopause (Dennerstein, Dudley, Hopper, Guthrie, & Burger, 2000). Lack of education about these expected changes can often be a source of undue distress for patients. Whereas male patients and their partners can benefit greatly from psychoeducation regarding normative aging and the effects on erectile response (see Chapter 2), female patients and their partners may similarly be uneducated about the effects of aging on female sexual response. Further, an important consideration is whether or not the woman has experienced this reduced or absent sexual interest/arousal as uniquely distressing, or if the problem lies more within a mismatch of level of sexual desire between the patient and her partner. It is not infrequently that we have seen such couples present for treatment, with low female interest being the presenting complaint. Upon interviewing, it is revealed that one partner has high levels of sexual interest and would prefer sexual activity daily or even more frequently. The identified patient has a preferred sexual frequency of once or twice a week. This mismatch of interest level would not be diagnosed as female sexual arousal/interest disorder.

PREVALENCE

As the diagnosis of female sexual interest/arousal disorder is new, prevalence studies using the DSM-5 criteria have yet to be published. However, a large amount of previous work independently examined the *prevalence of low sexual interest* (HSDD) and low sexual arousal (FSAD) in women. Though reported prevalence rates vary across studies, overall, low sexual desire is generally considered to be the most common sexual dysfunction symptom in women. One of the most frequently cited prevalence studies found low sexual interest in as many as 22% of women in the general U.S. population (Laumann et al., 1999). Somewhat more recent international surveys have reported a similarly high prevalence rate. In a survey of women living in the United Kingdom, over 10% reported low sexual desire lasting 6 months or longer and over 40% reported low desire for at least 1 month (Mercer et al., 2003). A study of women in 29 countries reported rates of low desire ranging from 26 to 43% (Laumann et al., 2005). Overall, reported rates of low desire in women range from 20 to 40% (e.g., Lieblum, Koochaki, Rodenberg, Barton, & Rosen, 2006; West et al., 2008; Oberg, Fugl-Meyer, & Fugl-Meyer, 2004; Mercer et al., 2003; Laumann et al., 2005). Importantly, though, as Brotti (2010) points out, these rates are of self-reported low desire only. They do not take into account associated distress or interpersonal difficulty. When associated distress is examined, rates of HSDD in women are much reduced, and range from 7.2% (Bancroft et al., 2003c) or 8.3% (West et al., 2008) to 23% (Witting et al., 2008). Studies have thus identified a notable proportion of women who report little sexual interest or desire, but no associated distress (e.g., Oberg et al., 2004; Shifren, Monz, Russo, Segret, & Johannes, 2008; Dennerstein, Koochaki, Barton, & Graziotinn, 2006). Furthermore, the prevalence of HSDD, consisting of both low desire and associated distress, differ greatly across women of different ages, reproductive status, and ethnicity (Brotto, 2010). The highest rates have consistently been reported for young women with surgically induced menopause.

Similarly, surveys examining the *prevalence of sexual arousal problems* have not always included all the information needed to diagnose FSAD. Many did not inquire about distress, and others did not assess for lack of adequate stimulation. An interesting early survey of this question asked 100 couples about the presence of sexual arousal problems and found that nearly half of the women (48%) endorsed difficulty becoming sexually aroused. Thirty-eight percent of these women also endorsed lack of adequate foreplay, and thus would likely not have been diagnosed with FSAD (Frank et al., 1978). Most of the research on the prevalence of FSAD has focused on self-reported lack of vaginal lubrication. Approximately 2.6% of women have been estimated to have difficulty, persisting for at least 6

months, attaining or maintaining sufficient vaginal lubrication (Mercer et al., 2003). In a review by Graham (2010b), the prevalence of persistent lubrication problems (defined as lasting 3 months or more) was found to range from 2.6% (Mercer et al., 2003) to 28% (Dunn, Croft, & Hackett, 1998), both in samples of women living in the United Kingdom. Bancroft et al. (2003c) found that 31.2% of heterosexual women in the United States interviewed reported lubrication problems, but the time frame for this study was only the past month. In face-to-face interviews, Laumann et al. (1999) found that 20.6% of U.S. women reported trouble lubricating for at least several months during the past year. Research that has inquired about distress has found that a sizeable percentage of women reporting lubrication problems do not endorse associated distress (e.g., Bancroft et al., 2003c; Oberg, Fugl-Meyer, & Fugl-Meyer, 2004; Shifren et al., 2008). For example, Shifren and colleagues estimated the prevalence of sexual arousal problems in their epidemiological sample of U.S. women to be 25.3%, yet only 3.3–6.0% of women endorsed both arousal problems and associated distress. As with desire problems, nearly all studies have found that lubrication problems increase as women age, though these studies typically did not include menopausal women, and did not inquire about associated distress. It is quite possible that, as with changes in sexual interest, lubrication problems may be more frequent, but associated with less distress, in older women.

ETIOLOGY

Biological Factors

Biological factors related to *low sexual desire* in women have not been clearly established. The most frequently researched and discussed biological factor has been the potential role of endocrine levels in female sexual desire. Indirect examination of this question has long pointed to the likely links between androgen and estrogen and sexual desire. For example, prevalence studies have shown that sexual desire decreases after natural menopause, and that the rates of HSDD are highest in young women with surgically induced menopause, a state in which estradiol and testosterone levels drop sharply (Alexander et al., 2004; Dennerstein, Lehert, & Burger, 2005; Gracia, Freeman, Sammel, Lin, & Mogul, 2007). Further, research has found increased sexual desire reported in women near the time of ovulation (e.g., Bullivant et al., 2004; Diamond & Wallen, 2011; Pillsworth, Haselton, & Buss, 2004) and decreased sexual desire after chemical suppression of ovarian hormones in a sample of naturally cycling women (Schmidt et al., 2009).

However, more direct examination of the relationship between hor-

mones and female sexual desire has not yielded clear results. A study of young undergraduate women reported positive correlations between estrodial levels and sexual desire, and negative correlations between progesterone levels and sexual desire, as hormone levels fluctuated within these women's naturally occurring menstrual cycles (Roney & Simmons, 2013). However, the same study did not find associations of hormonal levels and sexual desire between women. Though this may have been due to lower power, it still fails to establish a connection that explains individual differences in women's level of sexual desire. Further, though some earlier work (e.g., Sherwin, 1998) reported that low testosterone could contribute to decreased sexual desire in women, more recent, large, epidemiological studies have found only minimal or no correlation between testosterone levels and sexual desire in women (Davis, Davison, Donath, Dennerstein, & Bell, 2005; Guthrie, Taffe, Lehert, & Burger, 2004; Santoro et al., 2005).

Thus, while the connection between desire and androgren levels in men has been shown repeatedly (see Chapters 2 and 7), this robust association has not been evident in women. As pointed out by Brotto and Luria (2014) and by Davis and colleagues (Davis, Guay, Shifren, & Mazer, 2004), the lack of clear findings may in part be due to the fact that current assays to measure testosterone are designed to assess testosterone in males, or to measure hyperandrogrenic states in women. Thus, future work in this area may eventually yield more clear results.

Endocrine levels have a somewhat more clear relationship with female sexual arousal than they do with desire. This is mostly via the relationship between estrogen and physiological arousal. Reductions in estradiol during menopause and lactation have been repeatedly shown to be associated with reduced blood flow and vasocongestion, resulting in reduced vaginal lubrication (e.g., Graziottin & Leiblum, 2005; Guthrie et al., 2004; Dennerstein et al., 2000; Simon, 2011).

Vascular and neurological problems may also lead directly to arousal problems. Impairments secondary to multiple sclerosis (Hulter, 1999; Lew-Starowicz & Rola, 2013), pelvic vascular disorder (Schover & Jensen, 1988), and diabetes (Spector, Leiblum, Carey, & Rosen, 1993) may lead to impaired arousal. However, higher rates of arousal problems have been reported in women not only with Typ. 1, but also Typ. 2 diabetes, as compared to controls, and these studies have not found a clear association between arousal and HBA1c levels (Wandell & Brorsson, 2000; Erol et al., 2002; Enzlin, Mathieu, Van Den Bruel, Vanderschueren, & Demyttenaere, 2003). Prescription drugs, especially SSRIs and SNRIs may also impair sexual arousal and vaginal lubrication in women (Frohlich & Meston, 2000; Kennedy & Rizvi, 2009) and there is some evidence that hormonal forms of contraceptives may adversely affect arousal (Smith, Jozkowski, & Sanders, 2014).

It is also important to consider the indirect effects of biological factors on sexual desire and arousal. That is, a chronic illness or new medical diagnosis may be accompanied by numerous psychosocial stressors, bodily pain, and/or changes in bodily functioning and appearance. All of these factors may in turn lead to decreased interest in sex.

Psychosocial Factors

A myriad of psychosocial factors may contribute to the origination and/or maintenance of low female sexual interest and/or arousal. These include social, individual, and interpersonal factors. As mentioned above, societal factors, such as early learning about sexual norms in a manner that teaches girls that being interested in sex is associated with being "bad" or sinful, can lead to long-term feelings of guilt associated with sexual interest, which can serve to suppress such interests. Guilt about sex and sexually conservative views have been associated with lower levels of sexual desire and female arousal problems (Nobre & Pinto-Gouveia, 2008; Woo, Brotto, & Gorzalka, 2012).

Individual factors may include current life stressors, psychological problems such as depression or anxiety, or a history of sexual trauma. A number of studies have found that previous sexual abuse is related to low sexual interest (e.g., Leonard & Follete, 2002; Oberg et al., 2002). About one-third of premenopausal women with low sexual desire and accompanying distress have been found to have current symptoms or a diagnosis of depression (Clayton et al., 2012). Further, depression may complicate the presentation of desire problems, as women with both HSDD and depression have been found to report poorer relationships and worse sexual function than women with HSDD and no depression (Clayton et al., 2012). Some research has also found that, similar to men with ED, performance anxieties, a related lack of erotic thoughts, and increased attentional focus on failure during sex can contribute to female arousal problems (Nobre & Pinto-Gouveia, 2008).

Interpersonal factors affecting desire and arousal may include general relationship conflicts with one's sexual partner and/or more specific relationship difficulties involving poor communication about sexual desires. It has long been known, and has repeatedly been established, that women's sexual desire is greatly influenced by the general quality of the relationship with their partner (e.g., Guthrie et al., 2004). For example, a large community study found that women's self-report of a poor relationship with her partner was associated with desire and arousal problems, even after controlling for other demographic, biological, and psychosocial risk factors (Jiann, Su, Yu, Wu, & Huang, 2009). Additionally, poor sexual compatibility with one's partner is associated with lack of sexual interest

and arousal in women. Witting and colleagues (2008) surveyed a large, population-based sample of women and found that compatibility problems, such as one's partner being more interested in sex than they are, not finding one's partner physically attractive, and too little foreplay were associated with women's reports of desire and arousal problems. Not surprisingly, the quality of one's relationship has been found to be an important predictor of sexual desire and arousal in same-sex female couples, as well as heterosexual couples (e.g., Tracy & Junginger, 2007). In a large national probability sample, Bancroft et al. (2003c) found that overall poor emotional well-being and negative emotional feelings during sexual interactions with one's partner were the most important predictors of sexual distress in women. For these reasons, sex therapy often involves working on general couple's issues and communication, as well as more specific sexual communication and problems. It is not uncommon that couples will present for sex therapy for desire or arousal problems, and we will find that general relationship problems are at the root of the problem.

CASE EXAMPLE: FEMALE SEXUAL INTEREST/AROUSAL DISORDER

Carol is a 52-year-old, heterosexual woman, employed as a teacher in a public high school. She presented to our clinic with a complaint of having lost interest in sex. She had been married to Darren, age 54, for 11 years. This was the second marriage for both Carol and Darren. Carol has a 20-year-old son from a previous marriage and the couple has a 9-year-old daughter.

Carol reported that she noticed her interest in sex waning gradually over the past 5 years, and that at the time of the assessment she had almost no desire for sex at all. Carol reported that previously, she and Darren were engaging in sexual activity approximately once or twice a week. Two years ago, she began often refusing his attempts to initiate sex, until eventually Darren stopped asking. It had been 9 months since they have engaged in intercourse. They had also stopped engaging in nearly all physical contact. Carol stated she felt it "wasn't right" to kiss Darren "hello," to take his hand, or to snuggle next to him, as this might lead him to think that she was interested in sex, and she didn't wish to disappoint him. She reported that she was not engaging in masturbation or having sexual fantasies.

Carol reported that she was raised in a very devout Catholic family and grew up believing that women who had strong sex drives were immoral. She stated that she had never engaged in masturbation until she went to college and heard female classmates discussing it. She reported that she had "a bit of a sexual awakening" in college, and had sex with a few dif-

ferent partners. She stated that throughout these experiences, during her first marriage, and during the early years of her relationship with Darren, she had a moderate interest in sex, and found herself able to "get into the mood eventually" even if she weren't interested from the very beginning. She reported that she always felt a little awkward about sex, however, and had never been in a sexual encounter in which she felt comfortable communicating with her partner about what she enjoys.

Carol reported that the last several years have been very stressful for her. Her mother has been ill and Carol has been responsible for coordinating her move into an assisted living facility and more recently into a nursing home. Further, there have been budget cuts in Carol's school district, and she feared that she will be laid off. Carol reported very busy days, working full-time and then rushing to after-school activities with her daughter and visits with her mother. Further, Carol reported that in the last several years, she noticed more vaginal dryness and that sometimes sex was uncomfortable for her. As it became less comfortable, it also became less enjoyable and she stopped looking forward to it. She reported that she never mentioned this problem to Darren, as she felt awkward discussing it.

Carol and Darren both reported that their overall relationship had suffered in the last couple of years. Darren reported feeling hurt, rejected, and angry as a result of Carol's lack of interest in sex. He stated that he felt that she had shut him out and he doesn't think that he has done anything to deserve this. Carol reported that she can tell that Darren is hurt and is angry with her. She stated that she feels guilty that she is hurting him, but his anger toward her only makes her less interested in having sex.

Comment

As mentioned above, there are multiple potential biological and psychosocial causes of desire and arousal problems in women. This case, like many we have seen, is one in which a number of these potential causes exist, and likely interact to maintain the problems. These included (1) Carol's upbringing being one in which she felt shameful about her sexuality and thus never learned to communicate about sex with her partners, (2) Carol's general feelings of life stress, (3) normative changes in vaginal lubrication with age, and (4) Carol and Darren's general communication skills and relationship problems. Treatment thus focused on each of these issues. Carol and Darren were each asked to consider what sex means to them, and what their conditions for good sex are. Carol was able to articulate that after a long day of taking care of others, both at work and at home, Darren's requests for sex felt like "one more demand" on her time and energy. This was more and the more the case as she sensed Darren's anger and as sex became uncomfortable. The pressure for intercourse was removed by banning

the couple from attempting this. Sensate focus exercises were introduced, with a focus on increasing the couple's ability to communicate what types of touch they liked, and regaining Carol's comfort and pleasure in being touched. As Carol's upbringing was one in which she often felt shameful about her sexuality and never learned to openly express her sexual desires, cognitive restructuring around the meaning of her own sexual interest was useful. Carol and Darren also benefited from communication skills training, both in and out of the bedroom, and increasing their general feelings of closeness, in part via scheduling enjoyable shared activities. Lastly, and importantly, Carol and Darren were provided with recommendations for silicon-based vaginal lubricants to use during sexual activity. The couple reported that they had never tried a lubricant, as Carol associated lubricants with "sexually immoral women." Importantly, successful treatment in this case likely depended on seeing Carol and Darren together, as a couple. Though Carol was the identified patient, her lack of sexual interest was maintained largely due to circumstances that involved Darren. Without his assistance and cooperation in fostering general feelings of closeness and intimacy, helping Carol feel appreciated, loved, and relaxed, and his agreement to let her set the pace with the sensate focus exercises, this case would have been much more difficult to treat.

7

Male Hypoactive Sexual Desire Disorder

DESCRIPTION AND CLINICAL PRESENTATION

Sexual desire refers to an individual's interest, motivation, or drive to engage in sexual activity. This includes thoughts and fantasies about sex. Male hypoactive sexual desire disorder is technically a new diagnostic category in DSM-5 (American Psychiatric Association, 2013), as previous editions of this manual included only a gender-nonspecific disorder, hypoactive sexual desire disorder, which could be applied to men or women (American Psychiatric Association, 2000). As just described in Chapter 6, a main difference in DSM-5 is that for women, sexual desire and arousal problems have been combined into one disorder. For men, there have been few substantive changes in the definition of hypoactive sexual desire disorder (HSDD) between DSM-IV-TR and DSM-5. The most notable change is that this disorder in now only defined for men, and thus labeled male hypoactive sexual desire disorder (MHSDD). Further, though hypoactive sexual desire disorder had previously required "persistent" low interest in sex, this is now operationalized, by requiring that the symptoms have occurred for at least a 6-month duration.

MHSDD is thus defined by persistent or recurrent lack of interest in sex, including lack of sexual thoughts, fantasies, and desire for sexual activity. These symptoms need to last at least 6 months and cause distress. Refer to the diagnostic criteria for MHSDD (302.71) as presented in DSM-5 (American Psychiatric Association, 2013).

Despite the consistency of this disorder for men across revisions of the DSM, there is still much that is unknown about the problem. Far less research has focused on low desire in men than in women. This is likely because low sexual desire is rarely the main presenting complaint for men in our clinics. Rather, men are more likely to present with ED, whereas

women are more likely to report desire concerns (Kedde, Donker, Leusink, & Kruijer, 2011).

Cultural norms can make it difficult for men to understand and report low sexual desire. As Zilbergeld (1999) points out, a common myth of male sexuality, held by both men and women, is that men are always interested in and ready for sex. In our experience, and that of other clinical experts (e.g., McCarthy & McDonald, 2009a), male sexual desire is much more complex and multifaceted than this picture suggests. Men, it turns out, are influenced by many of the same factors as women: aging, hormones, relationship issues, stress, mood, and anxiety. All these plus sexual problems in their partners can influence men's desire for, and interest in, sex. We recently conducted an assessment on a healthy 45-year-old single man, Mark. Mark was confused by his recent behavior and wondered if he might be suffering from low testosterone levels. An objectively attractive man, Mark reported that throughout the last decade of his life he would be occasionally offered sexual encounters from women he had just met. He reported that recently, this occurred while food shopping and again while at a party with some friends. He stated that whereas in the past he might have acted on such offers, he now had no desire to do so. In fact, he found these recent requests for sex to be distasteful. He stated that his friends teased him about turning these women down, and he wondered if something might be wrong. Testing revealed normal testosterone levels and further inquiry revealed that Mark did not have HSDD. He had relatively frequent thoughts and fantasies about sex and had interest in masturbation. Rather, he no longer had any interest in sexual intimacy with a stranger. Brief treatment was able to assist Mark in his discovery that his reasons for having sex with a partner and the meaning of sex had changed for him over time. Whereas in his youth, sex was solely for physical fun, he was now more interested in finding someone with whom to share his life. He stated that he felt "used" by women who wanted to have sex with him without wanting to get to know him. Though Mark did not have MHSDD, his story demonstrates our societal confusion about male sexual desire. Not only did Mark fear that something was biologically wrong with him for not wanting to have sex with anyone, anywhere, but his friends also teased him about this, implying that his feelings were abnormal. We assume that if this story was about a female patient her reaction, and that of her friends, would have been much different. It is unlikely that anyone would have thought she had a sexual dysfunction because she refused to have sex with strangers.

It is also important to rule out the possibility that reported male sexual desire problems are a marker of another, underlying problem or arousal pattern, rather than actual MHSDD. As Meana and Steiner (2014) point out, the presentation of low desire may at times be hiding the fact that desire exists but is being fulfilled outside of sex with the primary partner, or simply suppressed. Thus, it is crucial to assess for such factors when an

individual or couple present with complaints of low sexual desire in a male. As we discuss in Chapter 12, a thorough psychosocial assessment of sexual problems should always include individual, one-on-one, private meetings with each member of a couple. Not infrequently such an individual meeting reveals that though the couple presents with complaints of low desire in a male partner, he still has sexual interest and fantasizes and masturbates frequently. Rather, his interest specific to sex with his partner is low due to factors such as no longer finding him or her sexually attractive due to changes in their relationship and/or physical appearance over time; having a sexual affair; and/or having paraphiliac or atypical arousal patterns that are not being met during sexual activity with his partner. Careful, individual assessment of these factors is thus required before a diagnosis and treatment plan can be made.

The DSM-5 specifiers can be of use in clarifying some of these issues. When low desire is acquired more recently, rather than being lifelong, it is important to assess changes in health status, life stressors, and relationship factors around the time the MHSDD problem began, as these factors may become the target of your treatment plan. Similarly, assessing whether there are any situations in which the man experiences sexual interest is of great importance in determining whether low desire may be a product of relationship problems, of a low sexual attraction toward one's partner, or due to the patient satisfying his sexual interest outside of his relationship.

PREVALENCE

Prevalence of desire problems in men has been studied in epidemiological surveys that have failed to inquire about the full symptoms for HSDD. That is, though men have been asked whether they have had problems involving a low desire for, or a lack of interest in, sex, they have not frequently been asked whether this problem was persistent and haven't been asked if they find it to be distressing. Such studies have reported widely varying rates of low sexual desire, depending on study methodology and age of participants, though a relatively consistent finding has been that compared to younger men, older men more frequently report low sexual desire (e.g., Araujo, Mohr, & McKinlay, 2004; Fugl-Meyer & Sjogren Fugl-Meyer, 1999; Laumann et al., 1999, 2005). Reported prevalence of low sexual desire has ranged from between 4.8% in a U.S. survey (Laumann et al., 2009) to 41% among Swedish men ages 66–74 years (Fugl-Meyer & Sjogren Fugl-Meyer, 1999). Overall, though, the bulk of this research has reported that approximately 14–17% of men experience low sexual desire or interest (Frank et al., 1978; Laumann et al., 1999; Mercer et al., 2003; Najman, Dunne, Boyle, Cook, & Purdie, 2003; Fugl-Meyer & Sjogren Fugl-Meyer, 1999).

When studies have inquired about persistent lack of sexual interest,

the reported prevalence rates typically drop. For example, a large British study, the National Survey of Sexual Attitudes and Lifestyles (NATSAL), found that 17.1% of men, ages 16–44 years, reported a lack of interest in sex. However, only 1.8% of these men endorsed having a lack of sexual interest that lasted at least 6 months in the past year (Mercer et al., 2003). Similarly, in a study of men in the United States, ages 40–80 years, occasional lack of sexual desire was reported by 4.8% of men, but frequent lack of sexual interest was endorsed by only 3.3% of these men (Laumann et al., 2009). Unfortunately, we weren't able to find any published data specifically looking at the prevalence of MHSDD, defined by lack of interest, persisting for at least 6 months, and associated with distress. As Brotto (2010) points out, though rates of distress associated with low desire haven't been established for men, the findings in women suggest that many individuals may experience low desire without finding this experience to be distressing (see Chapter 6).

A recent study conducted an Internet survey of men living in Portugal, Croatia, and Norway, and inquired about "distressing low sexual interest lasting at least two months" (Carvalheira, Traeen, & Štulhofer, 2014). Though this definition isn't exactly that of DSM-5-defined MHSDD, it comes closer than that of most other studies of male sexual desire, as it includes both a distress and a duration criterion. This study found that 14.4% of men reported a distressing lack of sexual interest, lasting at least 2 months. Interestingly, unlike the studies discussed above that did not include a measure of distress, age was not associated with increased degree of distressing low sexual desire. Rather, this study found the highest prevalence of distressing low sexual interest in men ages 30–39. Thus, it is possible, that as with women, sexual desire may decrease in men with age, but may be most distressing when occurring in younger individuals.

In a number of the prevalence studies mentioned above, low sexual desire was the most commonly (Mercer et al., 2003; Fugl-Meyer & Sjogren Fugl-Meyer, 1999) or second most commonly (Najman et al., 2003) reported sexual problem, outranking the prevalence of erectile problems. This high prevalence in the general population does not mirror what is seen in clinical settings, where men are more likely to present with erectile problems (Kedde et al., 2011), nor does it mirror the relative proportion of research articles published on ED versus on MHSDD, a reported ratio of 30:1 (Meana & Steiner, 2014). One possibility is that cultural norms make it difficult for men to discuss a lack of sexual desire, whereas ED may feel more socially acceptable, as it is viewed by many as a biological problem. Another possibility for this discrepancy is that low sexual interest may not be distressing for many men, especially if it is not accompanied by comorbid ED. More research that directly inquires about the prevalence of low interest accompanied by distress is needed.

ETIOLOGY

Biological Factors

Biological factors may have a strong influence on male sexual desire. In particular, low testosterone levels have been repeatedly found to correlate with lower levels of sexual desire (Bancroft, 2005), both in the general population and in men for whom androgen levels have been medically suppressed (e.g., during treatment for prostate cancer; during a withdrawal period in clinical trials). Additionally, testosterone replacement in men with reduced androgen levels has generally been found to increase sexual desire, though this effect of testosterone administration is not seen in men with normal androgen levels (Corona, Rastrelli, Forti, & Maggi, 2011; Khera et al., 2011; Isidori et al., 2005). Hypogonadism, or low testosterone, has been found to occur in approximately 3 to 7% of men age 30 to 69 years, and 18% of men older than 70 years (Araujo et al., 2007). Thus reductions in testosterone levels may contribute to the relationship between aging and decreased sexual interest. Other endocrine disorders have also been implicated in low sexual desire, including severe hyperprolactinemia (very inflated levels of serum prolactin) (Corona et al., 2004, 2007; Maggi, Buvat, Corona, Guay, & Torres, 2013) and hypothyroidism (Carani et al., 2005; Maggi, Buvat, Corona, Guay, & Torres, 2013).

In addition to hormonal factors, a number of medications and medical conditions may inhibit sexual desire. Antidepressant medications, in particular SSRIs and serotonin/norepinephrine reuptake inhibitors (SNRIs), have repeatedly been found to be associated with reports of decreased sexual interest and desire (Clayton & Balon, 2009; Clayton, Croft, & Handiwala, 2014). Atypical antidepressants, such as buproprion, nefazodone, and vilazodone may have a lower incidence of sexual side effects, including reduced sexual desire (Clayton, Croft, & Handiwala, 2014; Clayton, Kennedy, Edwards, Gallipoli, & Reed, 2013).

Neurological disorders, such as multiple sclerosis (MS) are associated with low sexual desire, with over one-quarter of men with MS in one study reporting low sexual desire problems (Lew-Starowicz & Rola, 2014). High rates of low sexual interest have also been reported in men with inflammatory bowel disease (IBD), including Crohn's disease and ulcerative colitis. As many as 33–50% of these individuals report decreased sexual desire and/or satisfaction after being diagnosed with IBD. Because some medications used to treat IBD may lower testosterone, and because the most consistent decreases in desire were seen in men with IBD and comorbid depression, it is difficult to tease apart direct and indirect effects of the disease on sexual interest (O'Toole, Winter, & Friedman, 2014). Coronary disease and heart failure, renal failure, and HIV have also been associated with MHSDD (Bernardo, 2001; Lallemand, Salhi, Linard, Giami, & Rozen-

baum, 2002; Meuleman & Van Lankveld, 2005; Toorians et al., 1997), but it is also somewhat unclear in these medical problems to what degree of variance in desire levels can be attributed directly to the diseases, rather than to medications and/or the psychosocial stressors that accompany living with these chronic illnesses.

Psychosocial Factors

As with women (see Chapter 7), a large number of psychosocial factors contribute to desire problems in men. In fact, some research (Corona et al., 2004) has found that psychosocial factors may be more predictive of desire problems for men than are biological factors. Psychosocial factors may include individual problems (e.g., mental health problems, depression, anxiety, stress); relationship problems (e,g., poor overall relationship, communication problems, lack of sexual attraction to one's partner); and sexual and/or health problems in one's partner. Further, concern about other sexual problems in one's self, including worry about erectile performance, can contribute to low sexual desire in men.

Corona and colleagues (2004) sampled male outpatients who were seeking treatment for sexual dysfunction. In this sample, psychological symptoms were more predictive of low desire than were hormonal and other biological factors. Of the men with a history of psychiatric symptoms, nearly 43% had moderate or severe loss of desire; only 16% of those without mental health symptoms had desire problems. Further, individual factors, including higher levels of work-related stress, were also associated with low sexual desire in these men. Similarly, depression has repeatedly been found to correlate with low sexual desire (Carvalheira et al., 2014; McCabe & Connaughton, 2014; Pastuszak, Badhiwala, Lipshultz, & Khera, 2013; Schreiner-Engel & Schiavi, 1986). McCabe and Connaughton (2014) conducted an online survey of 311 Australian men. They reported that of men with low sexual desire, 47.6% had depression or dysthymia and 26.8% had an anxiety disorder, compared to just 15.3% and 9.5% of men without any sexual dysfunction, respectively. Given that anhedonia, or a lack of interest in things that one had previously found pleasurable, is a key symptom of major depression, it is not surprising that men experiencing depression may report less interest in sex.

The relationship between depression and anxiety and sexual desire may be somewhat complicated, however. Bancroft, Janssen, Strong, Vukadinovic, and Long (2003b) surveyed 919 white, heterosexual men and found that whereas 42% of men who experienced depression indicated that sexual interest decreased when depressed, 9.4% reported that interest increased when depressed. For anxiety, the direction of effects was even more mixed, with 20.6% reporting an increase in sexual interest when

anxious, and 28.3% reporting a decrease while anxious. An accompanying qualitative study suggested that some men, when feeling depressed, may seek out sexual activity as a means of self-validation, and that anxiety may increase desire in some cases due to seeking stress release. These results were mostly replicated in a sample of 662 homosexual men (Bancroft, Janssen, Strong, & Vukadinovic, 2003a). In this sample, 47% reported that they were less interested in sex when depressed, and 16% reported an increase in sexual interest when depressed. When anxious, 24% stated they typically experience an increase in sexual interest, and 39% stated that anxiety is associated with less sexual interest. However, it is important to note that the men in these studies were not diagnosed with MHSDD or other sexual dysfunctions, and were predominantly young and single. Further, the study relied on retrospective report of sexual desire during periods of depression and/or anxiety. Thus, these results may not generalize to older men or those with diagnosed MHSDD. Nonetheless, they are of interest in pointing out individual differences in the way in which mood may affect sexual desire.

In addition to broad psychological symptoms, specific individual psychological and cognitive factors are related to low sexual desire in men. These include cultural factors, such as sex guilt and restrictive attitudes toward sex, and also individual sexual performance anxiety and concerns about erectile functioning. For example, Carvalho and Nobre (2011) found that performance anxiety and thoughts about one's erection during sex, as well as having restrictive attitudes toward sex (e.g., endorsing belief in statements such as "It is not appropriate to have sexual fantasies during sexual intercourse") were associated with low sexual desire in men. Similarly, McCabe and Connaughton (2014) reported that performance anxiety, current negative attitudes toward sex, and feeling guilty about sex, as well as partner sexual difficulty contributed to sexual arousal problems. Self-confidence about erectile function was also a significant correlate of lack of sexual interest in an online study of 5,255 men living in Portugal, Croatia, and Norway. In this study, men with low levels of confidence in their ability to achieve and maintain erections were 4.9 times more likely to have experienced a lack of sexual interest (Carvalheira et al., 2014).

Interpersonal and relationship factors have also been shown to influence men's sexual desire. Having a partner who has sexual problems has been associated with low sexual desire in men (McCabe & Connaughton, 2014). In a large, multicultural, Internet sample, men in long-term relationships were more likely to report lack of sexual interest and personal distress than were men in short-term relationships (i.e., less than 5 years) (Carvalheira et al., 2014). Further, desire problems were associated with not finding one's partner attractive. Overall, relationship problems were among the most frequent self-reported reasons for desire problems, just behind fatigue and work-related stress (Carvalheira et al., 2014).

Corona and colleagues (2004) have identified a "relational component," which they define as having a partner with (1) an illness that negatively affects sexual activity; (2) low desire, anorgasmia, or other sexual problems, such as difficulty expressing his or her own sexual interest; and/or (3) who is menopausal. In a number of studies, this relational component has been associated with the presence of low sexual desire in men with ED (Corona, 2006; Corona et al., 2004, 2009). Corona and colleagues (2004) also found that a poorer general relationship with one's partner was associated with MHSDD. Interestingly, Corona and colleagues (2009) found that among men with ED, this relationship factor was associated with less sexual activity, which in turn was associated with mild hypogonadism, thus suggesting that the association between relationship problems and low sexual interest may be bidirectional and self-maintaining.

The major impact and range of psychosocial factors contributing to MHSDD led Brotto (2010) to suggest that the DSM-5 specifiers for female sexual interest/arousal disorder should be applied for use in coding MHSDD as well. This suggestion, however, was not incorporated in DSM-5. Whereas female desire and arousal problems can be coded with regard to partner factors, relationship factors, individual vulnerability factors, and cultural/religious factors, MHSDD does not include such codes. Therefore, it behooves sexual health providers to remember the importance of these issues and evaluate for their presence and impact in cases of MHSDD.

CASE EXAMPLE: MALE HYPOACTIVE SEXUAL DESIRE DISORDER

Silas is a 51-year-old man who has been married to 49-year-old Richard for 1 year. They have been living together for 8 years and both have successful professional careers. Silas reported that he and Richard have a positive relationship in all respects except for sex. Richard is very affectionate and craves frequent sexual encounters, while Silas avoids affection and reports very low desire for sex. Silas's low sexual desire was the reason the couple sought therapy. Silas reported in the initial assessment session that he was raised with a dad who showed no affection and both parents fought "continuously." Silas reported, during his solo interview, that he was able to masturbate to erotic/pornographic visual material and, on occasions, he had arousing anonymous sexual encounters. The anonymous encounters had been occurring secretly about every 2 months throughout most of his relationship with Richard. He felt very little guilt about his encounters but was worried about the potential medical risks and had been tested frequently for sexually transmitted diseases. Furthermore, the pattern of low sexual desire in a committed relationship had always been a problem for him.

Silas and Richard both agreed that at the beginning of their relationship sex was very satisfying. However, within the first year of their relationship, sex became increasingly infrequent and, unfortunately, they never discussed this problem. Richard stated that he found their relationship very rewarding, so he "just accepted the lack of affection and decline in sex."

Richard's acceptance of the decrease in sex came to an end in the past year when sex declined to once every 6 months. This was the impetus to seek help. Therapy focused on helping Silas challenge negative messages about sex and helping Silas to accept and value intimacy as an important part of any long-term committed relationship. After five therapy sessions, the couple reported that they decided to separate for 1 year. They had concluded that Silas's lack of sexual interest in Richard was unlikely to change and both felt they needed a break from each other but they didn't want to "call it quits." Silas decided to stay engaged in therapy on an individual basis to address what he now saw as an "addiction" for risky anonymous sex. He also wanted to continue to work on building his capacity for intimacy.

Comment

Silas's low sexual desire was specific to long-term committed relationships. He found anonymous/risky sexual encounters very arousing. The diagnosis of hypoactive desire disorder would add the specifier "specific to certain partners and conditions." Both Silas and Richard found living together very satisfying in spite of the infrequency of sex. When the opportunity for a legal marriage became available, they did not hesitate to proceed. Richard stated that he was hopeful that a legal marriage would be reassuring to Silas and inspire more affection and sexual activity. When this hope was not realized, Richard became discouraged and finally felt hopeless about any change.

Silas harbored a misunderstanding that the intensity of sex should persist in a relationship no matter how many years a couple was together. We have found that this expectation has been common in many couples. Silas, unfortunately, contrasted the intensity of his sexual experiences during anonymous sex with the loving and tenderer experiences with Richard. Therapy provided normative information and realistic expectations but, unfortunately, too much hurt and discouragement overshadowed the possibility of change. Therapy often serves to help couples make decisions about their relationship even if the decision is to dissolve the relationship. Silas and Richard had been in a sexually unfulfilling relationship for about 7 years and, like many couples, had not been able to affectively discuss their predicament.

8

Genito-Pelvic Pain/Penetration Disorder

DESCRIPTION AND CLINICAL PRESENTATION

Genito-pelvic pain/penetration disorder (GPPPD) represents the merging of two DSM-IV-TR (American Psychiatric Association, 2000) sexual dysfunctions: dyspareunia and vaginismus. In prior versions of the DSM (American Psychiatric Association, 2000), dyspareunia referred to genital and pelvic pain and vaginismus referred to an involuntary tightening or spasm of pelvic muscles. The new DSM-5 (American Psychiatric Association, 2013) category of GPPPD applies to both of these conditions. That is, GPPPD refers to four symptoms of pain and/or penetration difficulties, which often co-occur. These are difficulty with penetration during intercourse, vaginal or deeper pelvic pain, fear of pain resulting from vaginal penetration, and tension of the pelvic floor muscles when penetration is attempted. A diagnosis can be made if marked difficulty exists in only one of these symptom dimensions. However, because these symptoms frequently co-occur, it is import to assess for the presence or absence of all four (Binik, 2010a, 2010b) in order to best formulate a treatment plan.

The creation of the GPPPD diagnostic category was made partly in response to reviews by Binik (2010a, 2010b) that questioned the validity of separate diagnoses for dyspareunia and vaginismus, primarily because of the large comorbidity between difficult vaginal penetration and painful sex. The majority of women diagnosed with vaginismus also experience vulvar pain upon gynecological examination (Basson, 1996; de Kruiff, ter Kuile, Weijenborg, & van Lankveld, 2000; Reissing, Binik, Khalifé, Cohen, & Amsel, 2004). In a recent survey of 500 Portuguese women, dyspareunia was comorbidly reported in 72.4% of women with vaginismus. Nearly half (47.7%) of the women with dyspareunia also reported vaginismus (Peixoto & Nobre, 2013).

A second change between DSM-IV-TR and DSM-5 has reflected the controversy as to whether or not vaginismus is actually characterized by a spasm of the pelvic muscles (Kingsberg & Knudson, 2011; Reissing et al., 2004). This definition of vaginismus, as an involuntary muscle spasm in the outer portion of the vagina, making penetration difficult or impossible, has been part of the DSM since DSM-III (American Psychiatric Association, 1980). As Binik (2010) points out, literature describing this condition dates back to at least the 1800s. Nonetheless, research has not verified that a spasm of pelvic musculature always accompanies the penetration difficulties reported by women with this problem. Thus, the GPPPD diagnosis no longer requires this involuntary muscle spasm.

A third controversy that arose in conceptualizing GPPPD was whether the problem was most accurately and usefully classified as a sexual dysfunction or as a pain disorder (Binik, 2010). That is, it has been proposed that perhaps these problems are more accurately considered pain disorders that interfere with sex, rather than sexual disorders characterized by pain (Kingsberg & Knudson, 2011; Binik et al., 2002). Research has shown that symptoms of genital pain disorders form a separate domain in construct analyses of sexual functioning measures (Fugl-Meyer et al., 2013; Rosen et al., 2000). Further, having a nonpelvic chronic pain disorder, such as migraine headaches, correlates with experiencing chronic genito-pelvic pain (Paterson et al., 2009). Additionally, genital and pelvic pain, and vaginal penetration problems, can occur outside of sexual situations and may be associated with more general, nonsexual, distress. For example, in some cases these symptoms may occur and be associated with anxiety during gynecological examinations or tampon insertion. In an epidemiological study of adolescent girls (Landry & Bergeron, 2009), 28% of sexual virgins reported severe pain at first tampon insertion. These girls were more likely to later develop dyspareunia, suggesting that pain during sex may be a symptom of a larger, vaginal pain issue. Thus, whereas other sexual dysfunctions most directly occur during and affect sexual enjoyment and functioning, genito-pelvic pain/penetration disorder can have direct, problematic effects outside the realm of sexual activity. Women with this problem may have difficulty adhering to gynecological health recommendations and may skip routine pelvic exams and pap smears. Inability to insert a tampon can impair general functioning, more so for patients who have lifestyles making use of a menstrual pad difficult (e.g., competitive swimmers). This disorder can also have clear implications for women wishing to become pregnant, whether through sexual activity or via assisted reproduction techniques.

Currently, in DSM-5, GPPPD is categorized as a sexual dysfunction. If, in the future, GPPPD isn't considered a sexual dysfunction, it will still remain highly relevant for practitioners who assess and treat sexual prob-

lems, as genital and pelvic pain can clearly have direct effects on sexual functioning and enjoyment.

Though not directly specified in the name of this diagnosis, by definition, this is a classification assigned only to women as it comprises vaginal penetration difficulties and pain. Exclusion of male dyspareunia from DSM-5 was primarily due to a lack of existing data, as very little research has been done in this area (Bergeron, Rosen, & Pukall, 2014). However, the sparse data that exists suggests that men can suffer from a number of medical conditions affecting their pelvic and genital organs, which may be associated with painful sex. It has been suggested that between 5 and 15% of men may experience painful sex (e.g., Bergeron et al., 2014; Clemens et al., 2005). As this chapter focuses on the DSM-5 category of genito-pelvic pain/penetration disorder, we will limit our review to sexual pain in women. Refer to the diagnostic criteria for genito-pelvic pain/penetration disorder (302.76) as presented in DSM-5.

Genito-pelvic pain and penetration problems are frequently comorbid with other sexual problems, particularly with low sexual desire. In a recent study of women living in Portugal, nearly half of the women with complaints of painful intercourse or vaginismus reported a lack of sexual desire (45.4% and 48.2%, respectively) (Peixoto & Nobre, 2013).

Painful and difficult sexual intercourse may not be frequently reported. One study found that only 60% of women with chronic genital pain ever sought treatment, and 40% of those women never received a diagnosis (Harlow, Wise, & Stewart, 2001). Thus, routinely inquiring about and screening for GPPPD symptoms, especially in women and couples presenting with complaints of low sexual desire or low frequency of intercourse, is essential.

PREVALENCE

As genito-pelvic pain/penetration disorder is a new category within DSM-5, its prevalence is currently unknown. Estimates exist for the prevalence of genital/pelvic pain or dyspareunia in women and for vaginismus. These estimates are somewhat difficult to interpret, however, as the range is great and varies widely between studies. Variations may be due to the age and cultural background of the women sampled, whether the sample is from the general population or from a sexual health or gynecological clinic, as well as differences in the manner in which sexual pain was assessed and defined.

With regard to dyspareunia, earlier studies reported fairly low rates in the general population, ranging from about 2 to 7% (Peixoto & Nobre, 2013). More recent estimates of the prevalence of painful sex have been reported to range from 6.5 to 45% in older women (van Lankveld et al.,

2010), from 14 to 34% in younger women (van Lankveld et al., 2010), and from 1 to 20% in adult women overall (Fugl-Meyer et al., 2013).

There has been a paucity of studies examining the prevalence of vaginismus. Earlier estimates were reported at less than 1% of the general population in Western countries (Fugl-Meyer & Sjogren Fugl-Meyer, 1999; Ventegodt, 1998), but more recently the prevalence has been reported as approximately 5 (Fugl-Meyer et al., 2013) to 6.6% (Peixoto & Nobre, 2013). Overall, it is thought that the best estimates of vaginismus prevalence rates in the general population vary between 0.4 and 6.0% (ter Kuile & Reissing, 2014).

Higher rates of vaginismus have been reported in clinical settings, suggesting that when this problem is present, it often leads individuals or couples to seek treatment. In a study of patients at a European sex problems clinic (Nobre & Pinto-Gouveia, 2008), vaginismus was the second most commonly seen female sexual problem, with 25.5% of female patients reporting this difficulty. The rates are even higher in countries in which women have fewer sexual rights and in which practices such as arranged marriages without bridal consent, child marriage, polygamy, and/or widow inheritance have been practiced. In one study (Amidu et al., 2010), 400 women living in an urban section of Ghana were surveyed using the Golombok Rust Inventory of Sexual Satisfaction (GRISS; Rust & Golombok, 1986). A cutoff point of 5 or more indicated the presence of a sexual dysfunction, and a score of 8 or 9 indicated a severe case. In this sample, 68.1% of women reported vaginismus, according to the GRISS (although only 6% were classified as severe cases). Another study (Yasan & Gürgen, 2009) sampled Turkish couples presenting at an outpatient mental health clinic for sexual problems. The most common diagnosis in this sample was vaginismus, present in 58.06% of the women. As Yasan and Gürgen (2009) report, in their sample the majority of couples had their marriage arranged by elders, and in over a quarter of the sample this was done without the consent of the bride. The high rate of inability for vaginal penetration in this sample may provide information about how psychosocial and cultural factors that affect the role of a woman in a sexual relationship can contribute to the etiology of vaginismus.

The relationship between GPPPD and age remains unclear. Some studies report higher rates of painful intercourse and/or penetration problems early in life (e.g., Dunn et al., 1998; Laumann et al., 1999; ter Kuile, Weijenborg, & Spinhoven, 2010; Traeen & Stigum, 2010), whereas others report that sexual pain and/or penetration problems increase with age (e.g., Amidu et al., 2010; Fugl-Meyer et al., 1999; Hawton, Gath, & Day, 1994; Osborn, Hawton, & Gath, 1988; Parish, Laumann, Pan, & Hao, 2007). For example, in one large epidemiological study of sexually active, adolescent, high school girls, approximately 20% experienced 6 months or

more of vulvovaginal pain during intercourse (Landry & Bergeron, 2011). One possibility is that the relationship between pain and age may not be linear. For example, it is possible that GPPD may peak both during adolescence/young adulthood and in postmenopausal, older women. Further, women are at increased risk for genito-pelvic pain following childbirth. In one study, 10% of women who experienced post-partum genito-pelvic pain continued to have these symptoms a full year later (Paterson et al., 2009). Thus, it is possible that this peak in symptoms postpartum may confound the ability to find a linear relationship between age and GPPD.

Overall, more standardized and cross-cultural research is needed on the prevalence of GPPPD, as reported rates of painful and difficult intercourse range so widely across studies as to make interpretation extremely difficulty.

ETIOLOGY

Biological Factors

Genital and pelvic pain occurring during or after intercourse may be caused and/or maintained by a number of biological factors. Identifying potential biological causes and maintaining factors can thus be essential to the development of an effective treatment plan for these problems. One of the most common biological factors initiating or maintaining dyspaurenia is estrogen deficiency and associated vulvovaginal atrophy and lack of lubrication.

There are also numerous biological and medical conditions that are associated with genito-pelvic pain. These include endometriosis, pelvic inflammatory disease, interstitial cystitis, uterine fibroids, genital infections (e.g., candidiasis, herpes, bacterial vaginosis), urinary tract infections, treatment of gynecological and other cancers with pelvic radiation and chemotherapy, congenital abnormalities and vaginal septum, scarring from episiotomy, prolapsed ovaries, and irritable bowel syndrome or inflammatory bowel disease (Fugl-Meyer et al., 2013; Kingsberg & Althof, 2009; Kingsberg & Knudson, 2011). Genito-pelvic pain has been found to be more common in women who experienced sex in early puberty, and those who used oral contraceptives from a younger age, or for longer time periods, suggesting areas for further biological research. Women with genito-pelvic pain have also been found to have lower general touch and pain thresholds (van Lankveld et al., 2010).

Far less research has examined the etiology of vaginismus. Genital malformations may infrequently account for penetration problems and some research has suggested that poor general pelvic floor muscle control and hypertonicity of the pelvic floor muscle may play a role (ter Kuile & Reissing, 2014).

Because of the strong potential for biological factors to influence sexual pain, these factors should be assessed by thorough medical examination prior to psychosocial treatment. This examination should include a medical history, a physical examination to look for malformations or signs of infection or scarring, cultures for possible infections, and a cotton swab test, in which the medical provider gently palpates different areas of the vulva using a cotton swab, while the patient rates her level of pain. Even if biological factors are identified, however, it is still crucial to assess psychosocial factors. Coexisting psychosocial factors, or those that develop over years of enduring painful sexual activity, can serve to maintain GPPPD even after medical factors are addressed. Additionally, in some cases there may be no easy solution for medical factors, and thus psychosocial approaches may be beneficial in assisting patients and their partners to adapt to and best cope with pain symptoms, often through altering sexual activity and expanding sexual repertoires to optimize activities less associated with pain.

Because accurate assessment of causal and maintaining factors will involve working with medical professionals (if you are not medically qualified to conduct this assessment yourself) it is important to know that medical providers may use terms for genito-pelvic pain other than GPPPD. Genital pain is often medically categorized as vulvodynia. The International Society for the Study of Vulvar Diseases defines vulvodynia as "chronic pain or discomfort involving the vulva for more than 3 months and for which no obvious etiology can be found" (Haefner, 2007). Vulvodynia can be further classified as unprovoked, provoked, or mixed (occurring both at times when unprovoked and provoked). Thus, there is clear overlap between dyspaurenia and provoked or mixed vulvodynia. "Vulvar vestibulitis" refers to a subtype of vulvodynia in which there is a painful response to touch or pressure around the vaginal opening. This term can thus also be used by medical providers to describe painful intercourse without known pathological causes.

Psychosocial Factors

Physical and sexual abuse have repeatedly been found to be risk factors for the development of GPPPD. An epidemiologic study comparing adult women with genito-pelvic pain to those with no pain complaints found that those with genito-pelvic pain were 4.1 times more likely to report having experienced severe physical abuse as a child, and 6.5 times more likely to have a history of severe childhood sexual abuse (Harlow & Stewart, 2005). Similarly, a study of adolescent girls found that sexual abuse and fear of physical abuse were both associated with experiencing genital pain (Landry & Bergeron, 2011). A review of this literature concludes that overall, women with dyspareunia are 2.67 times more likely than women with

GPPPD to report a history of sexual abuse (Latthe, Mignini, Gray, Hills, & Khan, 2006). Childhood sexual abuse may also be a risk factor for vaginismus, as women with vaginismus have been found to be two times as likely to report a history of childhood sexual abuse as women without pain or penetration problems (Reissing, Binik, Khalifé, Cohen, & Amsel, 2003).

A small body of research has also examined the role of relationship factors in GPPPD. Overall, general relationship satisfaction and dyadic adjustment have not been shown to contribute to dyspareunia (Desrochers, Bergeron, Landry, & Jodoin, 2008) nor to vaginismus (Reissing et al., 2003). However, this work has concluded that when male partners respond to pain complaints with hostility/frustration (e.g., "It doesn't really hurt, it's all in your head!") or with solicitious behavior and comments (e.g., "Does that hurt at all? Are you ok?"), GPPPD symptoms appear to worsen. Partner's facilitative responses that encourage adaptive coping (e.g., "Let's try something sexual tonight that you don't find painful") were associated with the best outcomes (Bergeron et al., 2014; Rosen et al., 2013), including lower pain intensity (Rosen, Bergeron, Glowacka, Delisle, & Baxter, 2012), whereas solicitious and hostile partner responses were associated with reports of higher pain intensity during intercourse (Desrosiers et al., 2008).

As GPPPD can be conceptualized as a chronic pain disorder, researchers and theorists have recently applied knowledge of the etiology of chronic pain to dyspareunia and vaginismus (Thomtén & Linton, 2013). Cognitive and behavioral factors, including fear of pain, pain-related anxiety, pain catastrophizing (i.e., thinking that pain will be unbearable), and pain avoidance have repeatedly found to be associated with the experience of chronic pain and disability (e.g., Vlaeyen, Kole-Snijders, Boeren, & van Eek, 1995; Vlaeyen & Linton, 2000; Crombez, Vlaeyen, Heuts, & Lysens, 1999; Asmundson, Norton, & Norton, 1999). In the fear-avoidance model of chronic pain (Leeuw et al., 2007), pain is thought to be maintained by a cycle in which people with higher levels of pain-related fear, anxiety, and catastrophizing allocate more of their attention to pain cues, worry about the negative consequences of pain and their perceived inability to cope with it, and then engage in behavior to avoid and/or escape from activities that they believe may trigger or exacerbate pain. This avoidance of activity further maintains the pain, through muscle disuse and disability, and through the lack of opportunity to learn corrective information about one's pain. Further, escape from activity that one fears will cause pain leads to a feeling of relief. This further reinforces the association between the activity and fear, and between escape and relaxation.

Research suggests that this model may apply to GPPPD. Women with chronic genito–pelvic pain have been found to show an attentional bias toward pain (Payne, Binik, Amsel, & Khalifé, 2005), increased fear of pain (Peters et al., 2007) and greater pain catastrophizing in general (Desro-

chers, Bergeron, Khalife, Dupuis, & Jodoin, 2009; Granot & Lavee, 2005) and specific to thoughts about sexual pain (Pukall, Binik, Khalife, Amsel, & Abbott, 2002).

Borg, Peters, Weijmar Schultz, and de Jong (2012) compared women with lifelong vaginismus, dyspareunia, and without any sexual complaints. They found that those with vaginismus endorsed greater pain catastrophizing than the other two groups, as well as a greater tendency to avoid pain and harm than did the women without any sexual problems.

More general anxiety states have also been implicated in the etiology of vaginismus. Investigators interviewed 154 women with chronic pelvic pain presenting to an outpatient gynecological clinic, and 58 age-matched controls. In the total sample of 212 women, vaginismus was associated with anxiety, depression, and sexual abuse history. Not surprisingly, higher rates of vaginismus were reported in the women with chronic pelvic pain. Interestingly though, the association between pain and vaginismus was mediated by anxiety, even after controlling for age and a history of sexual abuse (ter Kuile et al., 2010). This suggests that vaginismus may occur when pelvic pain is met with anxiety.

In addition to anxiety and fear of pain, disgust has been proposed as a psychological response that may underlie vaginismus. Theorists and researchers have proposed that disgust may have evolutionarily arisen as a means to keep us safe from contaminants. Think, for example, about your disgust in response to the appearance of rotting produce or the smell of spoiled milk. Our withdrawal from disgusting stimuli keeps us safe from things that might make us ill. As sexual interaction provides contact with potential disease contaminants, some researchers have posited that it could be a context in which disgust might be elicited (e.g., Borg, de Jong, & Weijmar Schultz, 2010; de Jong, van Overveld, & Borg, 2013). These researchers have conceptualized the tightening of pelvic floor muscles to be a response akin to flinching. Research in this area has supported this idea. For example, women with vaginismus have a greater tendency toward a disgust response to general, nonsexual cues than do controls (de Jong, van Overveld, Weijmar Schultz, Peters, & Buwalda, 2009) and women with vaginismus evidence facial disgust responses to erotic films (Borg et al., 2010). In a recent study (Borg et al., 2014), investigators conducted functional magnetic resonance imaging (fMRI) brain scans of women with vaginismus, vulvar pain without pelvic muscle tightening (dyspareunia), and women with no sexual dysfunction. They were seeking to test whether women with vaginismus would show stronger convergence in the way their brains' respond to general disgust pictures and to pictures of sexual penetration. Interestingly, the researchers found that there was large overlap between brain responses to images of sexual penetration and general disgust images (e.g., animal mutilation), but that this overlap was seen to the

same degree in all three groups of women. That is, even women without any sexual problems evidenced overlap in the way that their brains processed sexual penetration and disgust images. The authors suggest that some penetration/pain disorders may thus be the result of an impairment to overrule or inhibit this disgust response (Borg et al., 2014; de Jong et al., 2013).

Reissing (2012) conducted an online survey of 73 women with lifelong vaginismus and 93 with acquired vaginismus. Participants were asked to rate 53 possible attributions for their problem, ranging from "I believe my vagina is too small" to "I expect intercourse to be painful because someone I know told me stories about it." The most commonly endorsed reason for vaginismus was fear of pain based on previous painful attempts at intercourse. Further, those with lifelong vaginismus endorsed a number of fear- and disgust-based attributions for their difficulties, such as the expectation that intercourse will be painful because of what they heard in the media, fear of injury, and disliking the idea of having a penis inside them.

As GPPPD may be caused and maintained by multiple biological and psychosocial factors, we join with other experts in this field (e.g., Bergeron et al., 2014; van Lankveld et al., 2010) in suggesting a multidisciplinary model of assessment and care for these problems.

CASE EXAMPLE: GENITO-PELVIC PAIN/PENETRATION DISORDER

Kathy, age 48, was referred by a therapist who had been treating her for dissociative identity disorder for several years. Kathy was in the medical profession and her 49-year-old husband, Larry, was a business executive. The therapist made the referral because Kathy had made significant progress overcoming her dissociative disorder and she expressed a desire to address some sexual concerns. She had recently revealed that she and her husband very rarely had sex and when they did, Kathy experienced considerable anxiety and muscle tension. Kathy and Larry had been married for 18 years and except for sex, they both reported that they got along very well. The couple had not had penetrative sex since their honeymoon, although about two or three times a year Kathy would manually masturbate Ken to the point of orgasm. On their honeymoon, Kathy cried and had a dissociative experience following intercourse.

In the initial interview with Kathy, she disclosed that she was sexually abused by an older male cousin over a number of years from approximately age 9 to age 12. The sexual abuse consisted of digital and penile vaginal penetration and oral sex. She never reported this violation to her parents because she felt they would have blamed her. As Kathy began discussing her childhood abuse, she suddenly became silent and her expression changed

to a very blank stare. Several minutes passed while Kathy maintained a coma-like trance until she finally responded to inquiries about what she was experiencing. Kathy explained that the discussion of her abuse triggered a flashback and a momentary dissociation. In addition to the sexual abuse perpetrated by her cousin, she also recalled sexually inappropriate verbal remarks and behavior by her mother who was diagnosed as schizophrenic. She recalled, at age 12, her mother stripped her naked in front of her aunt and uncle to show them her breast and pubic hair development. This was mortifying to her and was only one of many such embarrassing and traumatic experiences she had suffered at the hands of her mother.

Kathy stated that she was very comfortable with kissing, hugging, breast fondling, and masturbation. In fact, she expressed strong sexual desire and said she was orgasmic. She was adverse to any vaginal penetration, including the use of a Tampon, and she did not want to receive or provide oral sexual stimulation. She had undergone a recent gynecological examination and there were no physical findings that explained her pain. Larry, however, viewed her as being nonsexual and "going through the motions" since they did not engage in intercourse or oral sex. In a separate individual interview with Larry, he stated that he was very upset with her dissociative behavior, which occurred whenever he approached her for intercourse. He said that he finally gave up on sex and that he did harbor some resentment because of "her" sexual problem.

Therapy for the GPPPD included a referral to a physical therapist who worked with Kathy on a program of pelvic floor muscle relaxation, gradual insertion of dilators of increasing girth, and use of lubrication. In addition, Kathy was asked to challenge automatic negative thoughts associated with penetration and challenge the concept that she was nonsexual (a message she frequently heard from Larry). The evidence to support her challenge was that she had strong sexual desire and was easily orgasmic. Therapy also planned to include couple's practice with sensate focus followed by graduated digital and penile vaginal penetration.

From the start of therapy, Kathy made great progress in her physical therapy sessions. She was highly motivated and practiced at home daily. Within a period of 6 weeks, she was able to insert the largest dilator for several minutes without any anxiety or dissociative experiences. The couple's practice was a very different story. Larry found the practices very stressful and he was frustrated by attempting to follow a graduated approach to sex. After many weeks of stalled practice and avoidance, it was learned that Larry's sexual approach had always been very rough, and very goal-directed toward intercourse with very little foreplay. Larry also had a very large penis with greater girth than the largest dilator and he required long periods (10 minutes or more) of direct penile stimulation before reaching orgasm.

Therapy eventually stopped altogether. Although Kathy had gained complete comfort with penetration and a much more positive sexual outlook, Larry expressed resentment toward her and wasn't willing to adopt an approach to sex that included more foreplay and a more gentle style. Larry stated that he wanted to take a break and reevaluate his investment in the relationship.

Comment

This is a case of mixed results. While Kathy achieved her goal of comfortable pain-free penetration, the therapy process uncovered deep resentment on Larry's part that he had not previously expressed to Kathy. In addition, important factors about Larry's approach to sex were not identified until physical practice started. Kathy's pain and discomfort with vaginal penetration and her anxiety with both penetration and oral sex were related directly to her childhood abuse. In spite of her cousin's abuse and her mother's negative sexual messages, Kathy was able to identify and enjoy some very specific sexual behaviors. In women with GPPPD, the presence of areas of sexual comfort is always encouraging and greatly facilitates the treatment process by building on existing sexual strengths. It should also be noted that negative sexual messages in childhood alone are often associated with GPPPD.

This case underscores the importance of carefully examining both partners' sexuality in spite of the initial identification and presentation of one person as having the sexual problem. Although Kathy entered the relationship with a history of sexual abuse and negative sexual messages, Larry's all versus none rough approach to sex and his anatomically large penis most likely exacerbated Kathy's problem with penetration. Finally, 18 years of sexual avoidance, negative assumptions, and lack of communication took its toll on the relationship.

9

Substance/Medication-Induced Sexual Dysfunction, Other Specified Sexual Dysfunction, and Unspecified Sexual Dysfunction

DESCRIPTION AND CLASSIFICATION ISSUES

This chapter describes three separate, but related DSM-5 sexual dysfunction categories: substance/medication-induced sexual dysfunction, other specified sexual dysfunction, and unspecified sexual dysfunction. These diagnostic labels are similar to each other in that, unlike the disorders described in the previous chapters of this book, none of the disorders discussed in this chapter refer to a specific set of sexual symptoms. Rather, each of these diagnostic categories can be applied to a broad range of symptoms, including problems with sexual desire, arousal, erections, and/or orgasm.

Sexual problems are categorized as *substance/medication-induced sexual dysfunction,* rather than by their specific symptom category, if they occur in temporal proximity to beginning use, increasing dose, or discontinuation of a substance/medication known to have an effect on sexual functioning. For example, we recently conducted an assessment with Malik, a 45-year-old African Caribbean male. Malik reported a very close and enjoyable sexual relationship with his long-term partner. He stated that he had no history of sexual problems prior to 5 months ago, when he began experiencing difficulty attaining an erection. Malik reported that shortly before this problem began, his primary care provider had prescribed him hydrochlorothiazide as a means of managing his hypertension. Malik stated that nothing else in his life had changed at that time. Malik

was diagnosed with antihypertensive-induced sexual dysfunction. Sexual problems are captured as *other specified* or *unspecified sexual dysfunction* if, though associated with significant distress, the sexual symptoms don't meet full criteria for any of the other DSM-5 sexual dysfunctions. The *other specified sexual dysfunction* category is used if you wish to state the specific reason that the presentation does not meet the criteria for any specific sexual dysfunction. In this instance, you would first record "other specified sexual dysfunction" and then add the reason in parentheses. *Unspecified sexual dysfunction* is used if you choose not to specify the reason that the criteria aren't met for a specific sexual dysfunction and if there is insufficient information to make a more specific diagnosis. Please refer to diagnostic criteria for substance/medication-induced sexual dysfunction as presented in DSM-5.

Substance/medication-induced sexual dysfunction does not have its own, unique DSM-5 code. Rather, the numerical code is assigned by first identifying the class of substance or medication involved, and identifying whether or not, or with what degree of severity, the patient has a substance use disorder. An *International Classification of Diseases* (ICD) code is then applied for the specific substance and the specific substance is noted in the name of the disorder. For example, a patient who began experiencing sexual problems while using alcohol, and who has moderate alcohol abuse, would be noted as having a moderate alcohol use disorder with alcohol-induced sexual dysfunction. This coding process is explained in detail in DSM-5 (American Psychiatric Association, 2013).

The diagnostic criteria for other specified sexual dysfunction (302.79 [52.8]) applies to presentations in which symptoms characteristic of a sexual dysfunction that cause clinically significant distress in the individual predominate but do not meet the full criteria for any of the disorders in the sexual dysfunctions diagnostic class. The other specified sexual dysfunction category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific sexual dysfunction. This is done by recording "other specified sexual dysfunction" followed by the specific reason (e.g., "sexual aversion").

Diagnostic criteria for unspecified sexual dysfunction (302.70 [F52.9]) apply to presentations in which symptoms characteristic of a sexual dysfunction that cause clinically significant distress in the individual predominate but do not meet the full criteria for any of the disorders in the sexual dysfunctions diagnostic class. The unspecified sexual dysfunction category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for a specific sexual dysfunction, and includes presentations for which there is insufficient information to make a more specific diagnosis.

MEDICATIONS/SUBSTANCES COMMONLY ASSOCIATED WITH SEXUAL DYSFUNCTION

A number of different medications and substances have been associated with sexual dysfunctions. The classes of prescribed medications most closely associated with sexual problems are antidepressants, antipsychotics, hormonal contraceptives, and antihypertensives (Balon, 2006; Fusco, Franco, Longo, Palmieri, & Mirone, 2014). Recreational drugs and illicit substances including heroin, amphetamines, cocaine, cannabis, alcohol, and tobacco may be associated with sexual dysfunction. An exhaustive review of these substances and the mechanisms by which they may interfere with sexual functioning is beyond the scope of this book. Rather, the purpose of this chapter is to provide familiarity with some of the medications and substances that may present a problem for patients with sexual dysfunction. As discussed in Chapter 10, a review of medications and substances that your patient has used is an important part of a sexual assessment. When the substances mentioned in this chapter are part of the patient's medical history, you will want to inquire in depth about the dates of use and any changes in dosages or frequency of use in order to establish a time line of these changes in temporal proximity to changes in sexual functioning.

Medications and Sexual Dysfunction

Antidepressants

Antidepressants are the class of medications with which sexual problems presenting in clinical practice can most often be associated. This is in part due to the high prevalence of antidepressant medication use. Among those taking antidepressants, medication-associated sexual dysfunction has been estimated to occur in approximately 34.2% of men and 32.5% of women (Williams et al., 2006). The most commonly reported sexual problem occurring during use of antidepressants is anorgasmia or delayed ejaculation, though some patients report low desire or erectile difficulty. In a systematic review of the literature, Serretti and Chiesa (2011) found that the rate of sexual dysfunction varied between specific agents, and was reported by 25 to 80% of men and women across these medications. Citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline, duloxetine, venlafaxine, imipramine, and phenelzine were associated with significantly higher rates of sexual dysfunction compared with placebo. No significant difference from placebo was found for patients taking agomelatine, amineptine, bupropion, moclobemide, mirtazapine, and nefazodone. In general, antidepressants with fewer 5-HT-2 effects tend to be associated with fewer sexual side effects (Fusco et al., 2014).

Antipsychotic Medications

Antipsychotic medications have been associated with low desire and arousal and anorgasmia in women. In men, these medications are associated with problems with desire, erection, retrograde ejaculation, and delayed orgasm (Schmidt et al., 2012). It has been estimated that nearly half of all patients taking antipsychotic medications will experience sexual problems (Fujii et al. 2010; Nunes, Moreira, Razzouk, Nunes, & Mari, 2012). One mechanism for increased sexual dysfunction associated with these medications is hyperprolactinemia (Haddad & Sharma, 2007; Rettenbacher et al., 2010). A recent meta-analysis (Serreti & Chiesa, 2011) found that rates of sexual dysfunction varied across different antipsychotic agents such that higher rates were seen for prolactin-raising medications. Prolactin-sparing antipsychotics (quetiapine, ziprasidone, perphenazine, and aripiprazole) were associated with relatively low rates of sexual dysfunction (16–27%), whereas olanzapine, risperidone, haloperidol, clozapine, and thioridazine were associated with rates between 40 and 60%.

Hormonal Contraceptives

Hormonal contraceptives have also been found to be associated with complaints of sexual dysfunction, primarily with increased rates of dyspareunia and decreased vaginal lubrication. Interestingly, although oral contraceptives decrease androgen levels in the women who take them, these medications have not shown a consistent effect on sexual desire. Research has shown that hormonal contraceptives have no effect, a decreased effect, or even an increased effect on sexual desire. The discrepancy across studies is likely due, at least in part, to differential methodology and the lack of randomization in many of the studies (Burrows, Basha, & Goldstein, 2012). For example, in naturalistic studies, it is possible that women taking hormonal contraceptives have a preexisting increased degree of sexual desire over women who are not regularly using birth control. This preexisting difference may confound any effect of the medications on sexual desire. Implanon, an etonorgestrel rod that is implanted in the upper arm, has, however, been shown to be associated with decreased sexual desire. In one study, 2.5% of women had the implant removed due to complaints of decreased desire (Gezginc, Balci, Karatayli, & Colakoglu, 2007).

Antihypertensive Medications

Though antihypertensive medications have frequently been thought to negatively influence sexual functioning, and erection problems in particular, data supporting this association is somewhat unclear. Overall, there is

great variation in the prevalence of these problems in men taking antihypertensives, with rates of sexual problems ranging from 2.4 to 58% of men on these medications (Fusco et al., 2014). This variation may be due to differences between agents. Thiazide diuretics appear likely to be related to an increased risk of developing ejaculation and erection problems (Fusco et al., 2014), while calcium channel blockers (CCB) and angiotensin-converting enzyme (ACE) inhibitors appear less likely to have a significant impact on sexual functioning (Fusco et al., 2014; Manolis & Dumas, 2012). Research on the effects of beta-blockers on sexual functioning is more mixed, leading to some debate over conclusions (Ko et al., 2002; Manolis & Dumas, 2012). However, a number of randomized trials have found greater reports of erectile problems in patients taking beta-blockers than placebo (Fogari et al., 2002). As such, it is likely safest to consider the possibility that beta-blockers are a contributing factor, if treating a male patient with ED who is taking these medications. There has been much less research on the effects of antihypertensives on female sexual functioning, so it is difficult to draw conclusions (Ferrario & Levy, 2002).

Substances of Abuse and Sexual Dysfunction

Heroin

The clearest connection between illicit substance use and sexual dysfunction is likely for patients using heroin (Zaazaa, Bella, & Shamloul, 2013). Individuals dependent on heroin consistently report higher rates of sexual problems (e.g., Bang-Ping, 2009; Palha & Esteves, 2002), including problems with desire, arousal, and orgasm. In a study comparing male patients at a drug treatment center with control participants, heroin users were nearly five times as likely to report erectile dysfunction as were controls (Bang-Ping, 2009). Increased risk of sexual dysfunction may continue in heroin-dependent patients during agonist treatment. For example, one study reported that 68.5% of men in a methadone maintenance treatment program experienced ED (Nik Jaafar et al., 2013). A recent meta-analysis (Yee, Loh, Hisham Hashim, & Ng, 2014) concluded that the rate of sexual dysfunction is much lower among patients receiving buprenorphine than those maintained on methadone. Thus, the authors recommend consideration of switching opioid agonist treatment from methadone to buprenorphine in patients who have sexual complaints.

Cocaine

Many men who use cocaine report that initially it may enhance their sexual functioning (Weatherby et al., 1992). However, prolonged use appears

to be associated with low sexual desire, erectile difficulty, and difficulty achieving orgasm (Rawson, Washton, Domier, & Reiber, 2002). ED may be present in as much as 66% of men using cocaine for a year or more (Cocores, Miller, Pottash, & Gold, 1988).

Amphetamines

Amphetamines have also been implicated in sexual dysfunction (Zaazaa, Bella, & Shamloul, 2013). Amphetamine-using patients have been found to be 3.2 times as likely to have ED as were controls. Many of these patients (22.6%) simultaneously reported that amphetamines increased their sexual desire (Bang-Ping, 2009). In particular, prolonged use of methamphetamine has been noted to be associated with a state of high sexual desire, accompanied with erectile difficulty. This phenomenon is sufficiently common among users of meth that it has earned itself an entry in the urban dictionary as "crystal dick" (Hirshfield, Remien, & Walavalkar, 2004).

Cannabis

There has been limited research into the effects of cannabis on sexual functioning. This work mostly focuses on erectile functioning, but has not typically used standardized measurement. Results have overall failed to establish a link between cannabis use and sexual dysfunction, though mechanisms by which deleterious effects may exist have been proposed (Shamloul & Bella, 2011). Further, some research has reported a beneficial effect of cannabis use, in the short term, on sexual functioning (Halikas, Weller, & Morse, 1982). However, in a large epidemiological study (Johnson, Phelps, & Cottler, 2004), after controlling for demographics, health status variables, psychiatric comorbidity, and alcohol use, marijuana use was associated with difficulty achieving orgasm and with dyspareunia.

Alcohol

Alcohol may also lead to sexual difficulties. In a study of male inpatients hospitalized for alcohol dependence, 68% reported sexual dysfunction (Pandey, Sapkota, Tambi, & Shyangwa, 2012). In men chronic alcohol use has been found to significantly increase the odds of ED (Chew, Bremner, Stuckey, Earle, & Jamrozik, 2009) and delayed orgasm (Johnson et al., 2004). In particular, drinking more than eight drinks a week was associated with an increased risk of ED (Chew et al., 2009). Studies examining the effect of alcohol on female sexual function are very limited, with inconclusive results (Peugh & Belenko, 2001).

Tobacco

Tobacco is also implicated in sexual dysfunction. Because nicotine is a vasoconstrictor, it can reduce blood flow to the genitals (Palha & Esteves, 2008; Cao et al., 2013). Further, it may reduce vasoactive substances, such as nitric oxide, in the vascular endothelium of the genitals and can affect both testosterone and estrogen levels (Zaazaa et al., 2013). As such, it is not surprising that tobacco smoking has been found to increase risk of ED (Gades, Nehra, Jacobson, et al., 2005; He et al., 2007). Stopping smoking, even for short periods of time, can improve sexual function (Peugh & Belenko, 2001) and quitting entirely can lead to long-term improvement in sexual functioning (Chan et al., 2010). We have found that providing patients with this information can be a very useful tool not only for improving their sexual health, but toward bettering their overall health. An understanding that quitting cigarettes may lead to better erections can be used to enhance a patient's motivation to quit. Unfortunately, little research has focused on the clinical effects of nicotine and tobacco on female sexual functioning.

CASE EXAMPLE: ANTIDEPRESSANT-INDUCED DELAYED EJACULATION

Carlos was a 32-year-old Latino. He was employed as a sales executive for an electronics company. He had been married to Kim for 3 years. The couple presented for assessment and treatment, with the complaint that Carlos was rarely able to ejaculate, even after prolonged stimulation. Carlos had been promoted to a more senior position in his company last year. The couple stated that they now were hoping to become pregnant. Carlos's sexual difficulty was thus quite distressing to them both. Further, Kim reported that she was beginning to lose interest in sex because "it is starting to feel like a lot of work." She also reported that she would become aroused and achieve orgasm fairly easily, and that sexual activity would then continue for a long while (sometimes up to 40 minutes of different types of stimulation), until Carlos eventually ejaculated or they both gave up.

Individual assessment with Carlos revealed that he was finding his new job extremely stressful, and had seen his primary care physician about symptoms of anxiety and worry he was experiencing. His physician had prescribed paroxetine, which Carlos began taking approximately 9 months prior to our meeting. He reported that his difficulty with ejaculation began about 7 months ago, and questioning revealed that this was about 2 weeks after his dose of paroxetine had been increased. Carlos reported that prior to this increase, he had no problems with ejaculation or orgasm. He denied other sexual difficulties, aside from very occasional erectile difficulty, which

was not of concern to him. Carlos reported that he and Kim had always had a very active and enjoyable sex life, and that he felt that their sexual connection was one of the main bonds in their relationship. Carlos noted that currently he was extremely worried and anxious about his ejaculation difficulties as he knew how badly Kim wanted to become pregnant, and he felt that she was becoming annoyed with him. He reported a fear that if he couldn't "fix this problem" it might lead to the end of his marriage. Carlos stated that during sex, he had become extremely focused on whether or not he was going to ejaculate, and had difficulty thinking about anything else.

Given the timing of the onset of these difficulties and the change in medication likely to cause delayed ejaculation, Carlos was diagnosed with antidepressant-induced ejaculatory delay. It was recommended that he speak to his primary care physician about switching to a medication that might have anxiolytic effects, without as large a risk for sexual side effects. His provider switched him to buspirone. Additionally, given the concerns that Carlos had developed about his ejaculation problems, and the amount of attention he allocated to these worries during sex, it was recommended that the couple follow up for brief sex therapy.

Within about 2 weeks of switching medications, Carlos and Kim began to notice that Carlos was achieving ejaculation more often, and somewhat more quickly. However, they reported that things still didn't seem "quite like they used to be" in that they both felt sex had become less playful and fun. Carlos confessed that he feared that Kim was getting bored if he was "taking too long" and that he still worried about ejaculating long after she had achieved orgasm. Kim reported that she felt she was often attempting to delay orgasm, not for her own pleasure, but in an attempt to reassure Carlos, and that she would sometimes daydream and lose focus during sex.

Comment

Carlos's sexual difficulties were quite likely induced by his antidepressant medication, though it is difficult to ever be completely certain of this during assessment. Carlos's recent job change and increased stress could also have contributed to the start of his problems. Regardless of the initial cause of his problem, Carlos's difficulties were maintained by psychosocial factors in addition to the medication. The pressure to ejaculate and to impregnate Kim was leading Carlos to focus his attention during sex nearly entirely on his worries about ejaculation. Thus, though switching medications lead to some alleviation of his difficulties, the couple remained somewhat dissatisfied with their sex lives. This result highlights the importance of a thorough biopsychosocial assessment, even in cases that appear to be clearly medication- or substance-induced. Cognitive-behavioral treatment was employed to assist this couple in regaining attentional focus on pleasurable and erotic

cues during sex, and to build more play and fun back into their relationship.

Similarly, we have not infrequently treated patients whose sexual problems appeared to have been caused by alcohol or opiate intoxication, but who continued to struggle after sobriety. One pattern we have seen a number of times is that the individuals used the substance prior to all sexual activity from an early age. In this manner, they never learned how to express themselves sexually when sober. Sexual communication training, and sensate focus exercises in which the patient can learn more about the sensations that he or she finds pleasurable, have often been useful in these cases.

PART II

Assessment of Sexual Dysfunction

In Chapters 2–9, we described the sexual dysfunctions and provided information on their prevalence and etiology. Now that you have an understanding of the sexual dysfunctions, we turn our attention to the practical tasks of assessment and treatment in Parts II and III. In Chapter 10, we present the model for assessment. Through this model, the reader will gain an understanding of how to approach a comprehensive assessment of all sexual dysfunction problems. By covering each area in the model, a therapist will gain an understanding of all possible contributing factors to a patient's sexual problem(s). In Chapter 11, we identify the common ingredients in the medical assessment of all sexual dysfunctions and we emphasize the important medical information that nonphysicians would benefit from knowing. We also discuss specialized medical procedures necessary for assessing specific types of sexual dysfunction. In Chapter 12, the final chapter of Part II, we discuss the common ingredients of psychosocial assessment of sexual dysfunction and what physicians should know about the psychosocial assessment. Finally, we discuss special challenges to psychosocial assessment including patients presenting with atypical sexual behavior and gender dysphoria.

10

Assessment Model

BACKGROUND OF THE MODEL

When a physician or mental health clinician is presented with a patient concerned about his or her sexual behavior, the challenge is to figure out what factor or factors are contributing to the patient's sexual problem. The specific treatment approach that is most effective for addressing a sexual dysfunction problem in a male or female is dependent on a comprehensive assessment that includes all important biomedical and psychosocial factors for that person. In many cases there may be a single factor that appears to be the primary causal agent for a particular problem, but a comprehensive assessment may identify other contributing factors that may also need to be addressed before a sexual problem can be fully resolved. For example, a male presenting with ED may be found to have below-normal testosterone levels. Although it is well known that low testosterone levels in men can cause ED, a comprehensive assessment may indicate that the male is also experiencing performance anxiety. A full resolution to his ED problem may involve not only testosterone replacement therapy but also therapy that specifically addresses his performance anxiety.

In any clinical diagnosis, it is also important to evaluate whether the problem is *lifelong* or *acquired* and whether the problem is *specific* to a certain person or set of circumstances or *generalized* across all people and all circumstances. The determination of "lifelong versus acquired" and "specific versus generalized" is much easier to make if the person presenting with the sexual problem has had a variety of sexual experiences with a variety of partners both past and present. It is also helpful if the person has past and present masturbatory experiences. The prescription and course of treatment will be completely different depending on which parameters are present. For example, if a female presents with low desire that is found to be specific to her partner but not toward other individuals, the treatment

would focus on the couple's relationship. On the other hand, if a female presenting with low desire feels low desire toward *all* potential partners, including those in fantasies and erotica, then the focus would be more on her individual medical and psychological profile.

It is sometimes very difficult to make the determination of specific versus generalized if a person has had only one sexual partner and does not masturbate. Masturbatory experiences can provide an index of desire and function separate from relationship to one's partner. If a person denies masturbatory experiences, one additional avenue that may provide at least limited information separate from a partner's influence is to explore the person's sexual fantasies.

In assessing sexual dysfunction problems, it is also important to identify the *time line* of the problem and consider *predisposing, precipitating,* and *maintaining* factors for both biomedical problems and nonmedical problems. Examples of time-line factors for both medical and nonmedical factors that may contribute to sexual dysfunction are as follows:

1. Predisposing biomedical problem	type I diabetes
2. Predisposing psychosocial problem	sexual abuse
3. Precipitating biomedical problem	SSRI medication
4. Precipitating psychosocial problem	divorce
5. Maintaining biomedical problem	hypogonadism
6. Maintaining psychosocial problem	performance anxiety

Treatment for a sexual dysfunction problem may need to address a single time-line factor or more than one factor. For example, a man presenting with ED precipitated by the trauma of a divorce and maintained by performance anxiety may require therapy that addresses the divorce and possibly the residual effects that undermined his self-confidence as well as therapy that addresses performance anxiety. On the other hand, another man who also may have had the experience of ED following a divorce may not have any residual self-esteem issues and may only need therapy that addresses his performance anxiety.

THE ASSESSMENT MODEL

When a male or female presents with a sexual problem, the treating clinician must assess all factors that affect a person's sexual desire and sexual arousal. Desire is a person's libido or "horniness," while arousal is a person's response to sexual stimulation. Desire and arousal are both affected by biological and psychosocial factors, as presented in Table 10.1.

TABLE 10.1. Sources of Sexual Dysfunction

Biomedical factors
Direct pathophysiology
Indirect biomedical contributions
Psychosocial factors
Individual (self)
Relationship/partner
Environment (nature of the stimuli and conditions under which sex occurs)

Biomedical Factors

Direct Pathophysiology

Biomedical factors that *directly* cause sexual dysfunction problems may be pharmaceutical agents, specific diseases or medical conditions, or certain medical/surgical procedures. A very long list of pharmacological agents may contribute to a variety of sexual dysfunction problems including low desire in men and women, orgasmic difficulties in men and women, ejaculation problems in men, and ED in men. There have been a number of comprehensive reviews of the pharmacological agents that contribute to sexual dysfunction in the past (Segraves et al., 1985) and more currently (Yang & Donatucci, 2006). It is beyond the scope of this text to review the literature in this area. It should be noted, however, that the most frequently encountered medications related to sexual dysfunction are the SSRIs and cardiac medications. Certainly, individuals have idiosyncratic responses to medication and some individuals may find a beneficial effect of a specific medication while others experience impairment. Nonetheless, since many individuals find a direct relationship between the onset of sexual dysfunction and the medication they are taking, pharmacological agents must be considered an important part of the direct pathophysiology of the assessment model.

In addition to specific pharmacological agents, another direct pathophysiology to be considered as part of the assessment model is certain disease states, most notably, diabetes, cardiovascular disease, endocrine disease, and certain neurological diseases. Thus, in certain diseases, it is the disease itself that directly causes the sexual dysfunction by compromising blood flow to the genitals, or by impairing nerve impulses responsible for arousal and function, or by lowering hormonal levels that are necessary for sexual desire.

Finally, certain surgical procedures or medical treatments may directly

cause sexual dysfunction. For example, surgical procedures for prostate cancer directly traumatize or sever important nerves responsible for erections in men, resulting in transient or permanent ED. Similarly, the medical procedure brachytherapy (internal radiation therapy) can also result in ED for men.

In summary, there are many biomedical sources that are direct causes of sexual dysfunction in men and women. The assessment model underscores the importance of reviewing all potential sources of possible direct pathophysiological involvement in all sexual dysfunction problems.

Indirect Biomedical Contributions

By *indirect* biomedical contributions to sexual dysfunction, we mean any medical condition that does not have a direct pathophysiological effect on sexual functioning, yet will impact negatively on sexual functioning. Some medical conditions may indirectly effect sexual functioning by interfering with sexual desire. For example, men or women experiencing chronic pain may be in such discomfort that they have little thought of sexual activity and may not be receptive to a partner's sexual initiations. In addition, there are some medical conditions that may not interfere with sexual desire, yet once a person is sexually active, discomfort is provoked and, in turn, sexual functioning is interfered with. For example, a person with chronic obstructive pulmonary disease (COPD) may find that during sexual activity he or she is so short of breath that sexual activity must stop.

In either of the above conditions, objective measures of sexual functioning may appear as normal. For example, a man with COPD or chronic pain will continue to experience NPT and may respond with full erections to erotic visual material. However, this man may experience ED during sexual activity because of his "indirect" medical condition.

Psychosocial Factors

Individual (Self)

The term "individual" is used to identify all those factors that affect sexual functioning that are brought into a sexual encounter by the person presenting with a sexual problem. This includes the person's sexual history, personality, comorbid psychological disorders, and sexual skills. A person's *sexual history* includes the accumulation of positive and negative messages, observations, and actual behavioral experiences that have influenced the individual's attitude and comfort level related to sexual activity and to the nature of sexual stimuli. The powerful influences of religion and culture are also included in a person's history as part of "individual." A person's

sexual history will affect a person's positive or negative attitude about sex, a person's acceptance or rejection of specific sexual behaviors and stimuli, and even a person's willingness, or conditions under which, to initiate or participate in sexual activity. A person's sexual history also includes the idiosyncratic ingredients of attraction for a partner as well as the possible ingredients for an acquired lack of attraction for a partner. Idiosyncratic ingredients of attraction include physical characteristics such as height, weight, shape, hair and skin color, as well as personality characteristics such as dominating, submissive, emotionality, coquettishness, religiosity, and so on. Acquired lack of attraction for a partner is based on a history with a specific partner and includes possible physical changes a partner has gone through as well as the interaction with that partner that may have included violence, cruel and critical remarks, and infidelity.

Another component of "individual" is a person's *personality or way of viewing him- or herself and the world*. Ellis (1906) (with early intuition) described men with potency problems as "men of abnormally sensitive temperament" (vol. 2, part 3, p. 174; "Sex in Relation to Society"). Perhaps in confirmation of this early theme, the Massachusetts Male Aging Study (Feldman et al., 1994) identified men who were "submissive" as being at more risk for ED. Barlow (1986) and Weisberg et al. (2001) added further credence to the relationship between an individual's viewpoint and sexual dysfunction risk by identifying men with erection difficulties as having a self-critical attribution style and underestimating the magnitude of their sexual response. Finally, Nobre and Pinto-Gouveia (2006a, 2006b) argued that men and women with sexual problems were more likely to endorse sexual myths, feel powerless, and view sexual problems as internal and stable. All of the above studies strongly suggest that men and women with certain personality styles are more at risk for experiencing sexual problems.

Comorbid psychological disorders are those mental health problems that are highly correlated with sexual dysfunction problems in men and women. Depression is most often cited as a contributor to sexual dysfunction in men and women but many other disorders, if significantly severe, can also impact sexual functioning. We have frequently encountered patients complaining of sexual dysfunction who present with a number of possible mental health disorders. The following conditions are the ones we have most commonly seen: obsessive–compulsive disorder, generalized anxiety disorder, attention-deficit/hyperactivity disorders, and posttraumatic stress disorder. Most likely, the mechanism of action in these disorders is that a focus on sexual enjoyment is interrupted by worrisome or distracting thoughts. Persons more vulnerable to sexual dysfunction seem to be men and women who have difficulty sustaining pleasurable thoughts "in the moment" because their thought process is overshadowed and interrupted by nonsexual and nonarousing thoughts. There are other comorbid mental

health conditions that may also be added to the list, most notably, substance abuse disorders, paraphilia disorders, and gender dysphoria.

A final consideration of "individual" in our model is *sexual skills*. As in every other area of human behavior, there are people who are very skilled and those who are much less skilled. The sexual athletes among us seem to be individuals who are able to readily identify a partner's sexual preferences, are physically coordinated, and are flexible and varied in their approach to sex. On the other hand, the sexually challenged are those who lack coordination, imagination, sensitivity, and willingness to explore sexual variety.

Relationship/Partner

Although there are a number of individuals whom we treat who do not have a current partner, we are focused in this section on those individuals presenting with a sexual problem who do have an available partner. For these individuals, it is important to examine the nature of the relationship as well as the partner's biological and psychosocial history. Medical assessment of the presenting patient does not typically address partner issues, which is usually the purview of the psychosocially oriented clinician. It is not unusual for a person to present with the self-identification of having a sexual problem when, in fact, it is the relationship or the partner's problem that is the real issue. A common example of this is the man who presents with ED and identifies himself as having ED when the real issue is that his partner has no interest in having sex (whether he has an erection or not). The bottom line is that when a person with a partner presents with a sexual problem, the nature of the relationship and the partner's physical, sexual, and mental health history must be thoroughly examined.

The relationship may be embedded with past anger, deceit, or other issues that may have caused irreparable damage. These past issues may be so overwhelming that no amount of change that the therapist can render would now make a difference. This possibility should be explored during the assessment process. In addition, the partner may bring to the table personality issues, mental health concerns, and/or sexual prohibitions that directly interfere with sexual behavior. It may be the partner's issues alone or the interaction of the couple that is the cause of the presenting sexual problem and all of this must be focused on as part of the assessment process.

Environment

The environment includes the nature of the sexual stimulation as well as the conditions under which sex occurs. Detailed exploration of the "sexual

environment" is probably the most overlooked aspect of the assessment process. A clinician should never assume that there is a clear understanding of what exactly is happening when a patient says that he or she "had sex" with a partner. While one may assume a person is "having sex" with an enthusiastic stimulating partner and engaging in sufficient varied foreplay under private comfortable conditions, the reality may be quite different. It is extremely important for the assessing clinician to ask detailed questions about both the nature of the sexual stimulation and the conditions under which sexual behavior is occurring.

The nature of the sexual stimulation should explore the typical behaviors that are included in a person's involvement in sex and whether these behaviors are pleasing and salient to a person's partner and whether the partner's behaviors are salient and pleasing to the person. It is not unusual for people to never tell their partner what is pleasing since many people have difficulty talking about sex. Also, when communication does occur, it is often in terms of a negative communication such as "I don't like it when you squeeze my breasts" rather than a positive communication such as "I like it when you stroke me gently." There is also often a blaming tone based on the false assumption that "there is a right way to have sex and a wrong way and if it is not occurring the way I think it should, then it is wrong." The lack of communication or negative sexual communication may lead to a sexual environment that is lacking in relevant physical and psychological sexual stimulation.

The conditions under which sex occurs is also an extremely important part of the assessment model. Is there sufficient time without pressure for sex? Is there privacy? Are the surroundings comfortable? All of these questions should be thoroughly explored. Common problems we run into involve couples who have disparate work schedules (night shift vs. day shift) or intermittent separations due to work travel. When couples have compromised time schedules, this fact alone puts a great deal of pressure on having sex when time does permit. Since opportunities for sex are few, a couple will often engage in sex during an opportunity whether they feel like it or not. Other common problems in the sexual environment often have to do with the lack of privacy or the presence of interfering factors: crying babies, children, or in-laws in the home who may hear sexual sounds, or intrusive pets in the bedroom or bed. Needless to say, all of the above factors may contribute to sexual problems and must be considered as an integral part of the assessment model.

11
Biomedical Assessment

In the overview of this text, we identified a number of new medical developments since 2001 that have impacted the assessment and treatment of sexual disorders. In this chapter, we focus on the common biomedical assessment procedures in use today.

WHAT NONPHYSICIANS NEED TO KNOW

Psychologists, social workers, and other mental health practitioners without medical degrees should know the strengths and limitations of a medical evaluation of males and females presenting with sexual problems. In general, the nonphysician should know what to expect from an assessment by a primary care physician compared to an assessment by a specialist such as an urologist or a gynecologist. In addition, the nonphysician should know that most physicians do not have the time (or skills) to engage their patients in a detailed discussion of their psychosexual developmental history, mental health history, or partner relationship. While some primary care physicians have excellent skills to do so, most do not, and consequently a medical evaluation will often not include important information such as the presence of a sexual affair or an acrimonious relationship between a couple or a partner's mental health or sexual problems. Most patients will not bring up these issues spontaneously and must be asked directly.

The nonphysician should expect the primary care physician to assess the patient's complete medical and surgical history and identify any relevant medical/surgical events that have impacted on past and present sexual functioning. Specific germane diseases, medical conditions, or surgical procedures that have impacted on sexual functioning, or are currently impacting on sexual functioning, should be identified along with any pharmacologi-

cal agents used in treatment that may also impact on sexual function. In addition, the primary care physician will perform a comprehensive physical examination and provide results from standard laboratory testing such as complete blood count (CBC) and lipid profiles as well as selective laboratory testing such as an investigation of the hypothalamic–pituitary–gonadal axis. All outlying lab values should be identified and provided.

COMMON INGREDIENTS OF ALL BIOMEDICAL ASSESSMENT PROCEDURES

Most males and females who have concerns about their sexual functioning will first present their problems to their primary care physician. Primary care physicians today are unlikely to take a detailed sexual history, but will instead perform a focused symptom evaluation (Rosen, Miner, & Wincze, 2014). The initial evaluation will begin with a comprehensive *medical history* and *physical examination* and provide the physician with an opportunity for patient education and reassurance regarding normal genital anatomy (Rosen et al., 2014). The medical history will identify possible underlying medical conditions and medications interfering with sexual functioning and the physical examination may corroborate aspects of the medical history and sometimes reveal important physical findings (Montorsi et al., 2010). In most cases, however, a more focused evaluation of common biological contributors to sexual dysfunction will be necessary. Berry and Berry (2013) identify the following areas as most relevant for evaluation of biological factors associated with sexual dysfunction:

1. Cardiovascular factors
2. Neurological factors
3. Endocrine factors
4. Cancer factors
5. Medication factors

Cardiovascular Factors

Cardiovascular factors are especially important in relationship to male erectile problems. In fact, it is now strongly suggested that ED may be an early warning sign of later cardiovascular disease (Araujo et al., 2010; Inman et al., 2009). Rosen et al. (2014) point out that cardiovascular comorbidities including hypertension, hypercholesterolemia, diabetes mellitus, and the metabolic syndrome have also been associated with ED. There is little question that it is necessary for the primary care physician to assess cardiovascular health in male patients presenting with erection difficulties.

Neurological Factors

Neurological factors affecting sexual functioning have been identified in males and females (Rees, Fowler, & Maas, 2007; Tzortzis et al., 2008). The most common neurological disorders affecting sexual functioning are multiple sclerosis, Parkinson's disease, epilepsy, and brain trauma. Pharmacological treatment for some of these disorders may also have side effects impacting on sexual functioning. It is also common for men and women undergoing radical pelvic surgery to experience disruption of the autonomic nerves crucial for sexual responsiveness. Similarly, men undergoing radical prostatectomy almost always experience immediate ED even in nerve-sparing procedures. In such cases, nerves are traumatized and it may take up to 2 years to experience recovery of erectile function. In some cases, function never returns.

Endocrine Factors

Endocrine factors may be important to the sexual health of both men and women. In interpreting the results of hormonal levels, several points are significant. First, it is important to remember that levels may vary depending on the assay procedure used; thus, levels typically vary somewhat across laboratories. Second, values should be understood as falling along a continuum of possible values, and the concept of a normal *range* is important. Third, it is critical to know the measurement units that are being used.

In women, estradiol is considered important. Typically, results are presented in picograms per milliliter (pg/ml). Because estradiol values fluctuate with the phases of the menstrual cycle, menstrual phase should be known when the sample is obtained and interpreted. The normal range of plasma estradiol during the first 10 days of the cycle averages 50 pg/ml; during the last 20 days, it averages 125 pg/ml. (Men normally average 20 pg/ml at all times.) Values below the normal range for a particular phase may adversely affect vaginal lubrication.

In men, testosterone and prolactin are important. For testosterone, values are typically expressed in nanograms per deciliter (ng/dl) or in nanograms per milliliter (ng/ml). In the laboratories with which we work, the normal range in men is usually from 280 to 1,100 ng/dl, or from 2.8 to 11.0 ng/ml. (The normal range in women is 6.0–86.0 ng/dl.) Testosterone values need to be obtained during the early morning, because testosterone in males responds to a diurnal cycle, with the highest values recorded during the morning. You should also know that testosterone values are usually expressed as total testosterone; this includes both bioavailable and inactive testosterone. The bioavailable testosterone that influences sexual behavior is a fraction of the total and is composed of both free testosterone and albumin-bound testosterone.

Prolactin is a pituitary hormone that causes the breasts to enlarge and to secrete milk; it is also believed to be important for evaluating sexual desire in men. Specifically, higher levels of prolactin in men have been associated with decreased sexual desire. The normal range for prolactin in men and women (except for women during pregnancy and while nursing, when higher levels are observed) is 0–20 ng/ml. A value greater than 20 ng/ml warrants a repeat test, because it may intimate, among other conditions, the presence of a pituitary tumor. We have found that there are several reference books that help to understand test values, medications, and diseases. Porter and Kaplan's (2013) *The Merck Manual: Go-To Home Guide for Symptoms* is one such reference book.

Cancer Factors

Cancer factors that affect sexual functioning in males and females are a result of both direct pathophysiological pathways and indirect pathways. Cancers of the brain, for example, can directly affect sexual desire while other cancers that cause pain and discomfort may indirectly affect sexual desire and function. Some cancers such as breast cancer or testicular cancer may also have a profound psychological impact and evoke sexual guilt and shame. Most cancers also result in depression and behavioral withdrawal.

The treatment of cancer by surgery, chemotherapy, or radiation therapy has a risk of causing sexual dysfunction in males and females (Alterowitz & Alterowitz, 2004; Quah, Jayne, Eu, & Seow-Choen, 2002) as much as the cancer itself. Cancer treatment often results in subsequent injury to neurological, vascular, or hormonal mechanisms essential for sexual functioning.

Medication Factors

Medication factors that affect sexual functioning are one of the most important areas that primary care physicians assess. The primary care physician in comparison to a medical specialist is more likely to know and understand the wide range of medications that may adversely affect sexual functioning in males and females. The most common medications implicated in sexual dysfunction are medications used for the treatment of depression as well as those used for cardiovascular diseases and neurological diseases.

Following the completion of a medical history, physical examination, and a review of the above five areas, the primary care physician should be able to identify likely medical factors contributing to a patient's sexual dysfunction. The primary care physician will then treat the patient or refer the patient to a medical specialist for more in-depth and comprehensive evaluation. The primary care physician will, most often, refer patients who have

been identified as needing more specialized assessment to urologists, endocrinologists, vascular specialists, or neurologists. For example, patients with specific pelvic trauma who may be candidates for reconstructive vascular surgery or patients with complicated endocrinopathies will benefit from further specialized assessment (Rosen et al., 2014). One of the more common assessment procedures that is referred to a medical specialist is the evaluation of nocturnal erections in men presenting with ED. This referral is made to an urologist who has the specialized equipment and knowledge for this assessment.

The physiological recording of NPT is often achieved in a full sleep laboratory or center, and is still considered the "gold standard" of differential diagnosis in men. Briefly, the rationale for this procedure is as follows: If a man can obtain an erection during sleep (which most men do on a number of occasions per night throughout their life cycle) but cannot obtain an erection during partner stimulation, it is assumed that the source of the erectile dysfunction is "psychogenic" (or "functional"). In contrast, if a man cannot obtain an erection at night and has a restful sleep, it has been assumed that his erectile dysfunction is "organic."

Despite the promise of NPT, there are some challenges to its use and interpretation. An extended discussion of these challenges is provided elsewhere (see Meisler & Carey, 1990), so we wish to mention only two here. First, from a purely technical viewpoint, data indicate that NPT may be influenced by sleep problems (e.g., apnea, hypopnea, or periodic leg movements) not routinely assessed in the typical NPT evaluation. These sleep parameters may produce artifacts that can interfere with interpretation of NPT tracings. Second, from a practical perspective, NPT monitoring can be very costly. The procedure may require expensive equipment and necessitate that a patient spend 2 or 3 nights in a sleep center. As a result, this assessment procedure is well beyond the financial means of most patients.

One pragmatic alternative to the sleep laboratory has been the use of the RigiScan. The RigiScan is usually available in urology clinics that specialize in the treatment of male sexual problems. This device is used at home and is about the size of a videotape. It is worn by the patient in a thigh holster with two lead wires ending in circular transducers attached to the penis. The RigiScan records a full night's penis circumference and rigidity changes. The record is then downloaded into a computer and displays number of erections, and the fullness and rigidity of each erection. In our clinic, men are given the RigiScan equipment for a period of 3 nights. Very often, the data from the first night are flawed since the transducers attached to the penis continuously constrict and release causing disruptions in sleep. By the second and third night, however, men get used to the device and the recorded data from these nights are in most cases useful.

12
Psychosocial Assessment

In this chapter, we discuss the strategies and tools of the psychosocial assessment of sexual problems as well as the impact of sexual problems on the patient and his or her sexual partner. The impact of experiencing a sexual problem is a very important area for the clinician to assess since the impact seems to progress through different stages and can lead to a loss of self-esteem, anger, and complete alienation.

OVERVIEW OF ASSESSMENT

Comprehensive and accurate assessment is crucial to formulating a helpful treatment program. While the clinical interview will be the primary evaluation tool, in some cases brief self-report questionnaires can also be useful, and in other cases more protracted psychological testing may be helpful. Our evaluation process is conducted over from one to three sessions depending on partner involvement and the complexity of the issues. Please note that other clinicians may follow a different assessment model that may include up to four sessions, with the first session including both partners. During the first session of the four-session model, the clinician is afforded a more protracted opportunity to view a couple's interaction. The number of assessment sessions may be dependent on the caseload demands of a clinic or clinician as well as third-party payment or self-pay considerations.

Regarding clinical interviews, experience teaches that obtaining meaningful information is a skill that involves far more than just asking the right questions. Assessment can be especially challenging because most people are not comfortable discussing their sexual behaviors. Our patients are often nervous about discussing their sexual concerns and they need to feel relaxed and supported in order to become fully engaged in the therapeutic process. Furthermore, many individuals may have strong beliefs

about what sexual conduct is acceptable or unacceptable, and they may be offended if a therapist's views do not agree with their own. It is also important for the therapist to establish a common sexual language with patients. Do not assume that patients understand terms like "orgasm" or "ejaculate" or understand that orgasm and ejaculation are two separate physiological processes. Always err in the direction of assuming patients do not understand technical terms.

Assessment should begin with an appropriate introduction for the patient(s). During this time, the assessment structure and content should be outlined. We also try to strike a very casual tone similar to what might be used in discussing the weather or any other mundane topic. We might begin by saying:

> "Today, in this first interview, I would like to obtain some background information and get an understanding of what brought you here. I find it helpful to begin by talking to a couple together for a little while to answer questions, but then I would like to be able to spend time with each of you separately. [This, of course, assumes that a couple is present. In many cases, you will be talking only to an individual at the first meeting.] Thus, in this session I will talk to one of you alone; then, in our next session, I will talk to the other person. It doesn't matter whom I start with. It is up to you, but it may be best to start with whoever has the busiest schedule. [If medical information is not at hand or readily available, the therapist should remark to the patient(s) that often it is helpful in a comprehensive evaluation to have both medical and nonmedical information and that following your evaluation you may suggest the need for a medical assessment.]
>
> "On our third meeting, we can all meet together and I will review my thoughts about your situation. At this time, I will try to explain what I believe to be the factors that originally caused your difficulty, as well as any factors that may be maintaining it. If appropriate, I will outline a treatment plan, targeted toward the important factors, to help you. So that is what the process is like. Do you have any questions or issues you would like to discuss before we break up and I talk to one of you?"

As the therapist, you should also mention your credentials and let the couple know that you are comfortable dealing with sexual problems. You should convey to the couple the important message that overcoming sexual difficulties requires the cooperative efforts of both partners. This issue is necessary to address because there is often an erroneous belief that (1) one person is to blame for the problems, and (2) it is the role of the therapist to identify and "cure" the "guilty/sick" one. After you have addressed removing blame, it is then important to proceed with separate interviews in order

to gather accurate information that is unencumbered by a partner's presence. Time can be wasted if the partners are always seen together. Many individuals have hidden stories (e.g., affairs, homosexual interests) that would never be revealed in the presence of their partners, yet this information is vital for developing a case formulation and planning the therapy program. After you make introductory remarks, you should invite the couple to ask any questions they might have. The remainder of the first session is then spent interviewing one of the partners alone.

The second session is used to interview the other partner alone. The third session can be used to assess the interaction of the couple. During this session, you can observe how the partners communicate and interact with each other. Problems and strengths in communication readily emerge at this time—for example, you can assess how caring, hostile, honest, and so on, the couple appears to be. It is also important to determine how much trust each partner has in the other; we try to do this by comparing the amount of self-disclosure that occurs during the couple session with that in the earlier individual sessions. This third session is also designated to present an initial case formulation and provide an outline of the therapy plan.

In our work, we find that skillful interviewing serves as the cornerstone of the assessment process. Of course, this view is not unique to the domain of the sexual dysfunctions. Indeed, many fine articles, chapters, and books have been written on skillful interviewing going back 30 years or more (e.g., Morganstern, 1988; Pope, 1979; Turkat, 1986). We recommend that you study these works for the general information and insights they provide about interviewing. In this chapter, however, we focus our discussion on the issues that pertain specifically to interviewing patients about sexual problems.

Despite the importance of this issue, not all health professionals know how to react to a patient's sexual concerns. Numerous patients have reported to us that they have tried previously to discuss their sexual problems with their physicians or therapists but were met with embarrassment or lack of interest; as a result, the patients did not pursue their concerns. For example, a 70-year-old female patient told us that she tried to discuss her vaginal dryness problem with her physician. Unfortunately for our patient, the physician avoided further discussion of this problem and only later referred to it as her "other problem." She sensed his discomfort with the subject and did not raise the problem again. She later told us, "You know, my doctor was too embarrassed to even say the word 'sex,' so he made me feel weird for asking about it." A study by Read, King, and Watson (1997) provides additional evidence that sexual dysfunctions are often neglected by primary care physicians. Using a survey of patients in a primary care setting, they learned that 70% of the patients considered sexual matters to be an appropriate topic to discuss with their doctor. Thirty-five percent

of the men and 42% of the women acknowledged a sexual dysfunction in the survey. Despite patients recognizing the importance of sexual problems and revealing specific concerns, a later chart review indicated that sexual problems were recorded in only 2% of the practitioners' notes.

Another, more damaging example of physician's inappropriate reaction to their patient's sexual concerns has been when advice is given without a thorough assessment. We have encountered several cases in which heterosexual male patients have been told by their physicians to seek out other sexual partners if they were having trouble functioning with their wives. The possibility of creating additional sexual problems, as well as potential relationship and even possible legal problems, was seemingly never considered by these physicians.

Despite these risks, research going back 40 years indicates that self-disclosure, at least in moderation, is associated with improved mental health and relationship outcomes (Cozby, 1973). In general, women tend to self-disclose more than men. However, both men and women find it difficult to disclose sexual feelings, fantasies, and fears. Several investigators have reported that when asked to indicate the secrets that they would find be most threatening to disclose, individuals typically identify sexually related material as the most risky (e.g., Norton, Feldman, & Tafoya, 1974); this is especially true for women (e.g., Solano, 1981).

Thus, when we ask patients to disclose information about their sexual lives, we need to keep in mind that we are asking them to disclose their deepest (and for some, their darkest) secrets (Norton et al., 1974). Chances are good that they may not have disclosed this material to anyone, including their spouse or their closest confidante. The disclosure holds much promise for self- and relationship-related development and growth, but it remains quite risky for our patients.

Moreover, in a time when our popular culture is awash with sexual messages and communication—music videos, AIDS prevention messages, Internet chat sites, advertisements for products such as Cialis, Levitra, and Viagra—sexual concerns have increasingly been normalized and legitimized. This trend in popular culture has resulted in a greater likelihood that patients will bring forth sexual complaints to physicians and health care practitioners. Thus, it is important that all professional health care practitioners be skillful at handling these concerns and not create additional problems.

STEP-BY-STEP DETAILS OF INTERVIEWING: SESSIONS 1 AND 2

We begin by proposing that an interview will best serve the needs of the patient if you obtain important information in a sensitive and efficient man-

ner. Toward this end, we believe that the crucial components of an effective clinical interview include (1) making assumptions (hypotheses) before the interview; (2) setting goals for the interview; (3) attending to process throughout the interview; and (4) following a specific structure and content during the interview.

Assumptions

"Assumptions" are the hypotheses that a clinician makes in order to gather the most accurate information without wasting time and effort. Assumptions reflect the preferred direction of error. Thus, for example, it is better at the beginning to assume a low level of verbal understanding on the part of a patient and thus to direct language to the patient in a clear and concrete manner. Obviously, as a clinician learns more about a patient, these assumptions are adjusted.

Other examples of useful assumptions include the following:

- Clients will be embarrassed and have difficulty discussing sexual matters.
- Clients will not understand medically correct terminology.
- Clients will be misinformed about sexual functioning.
- Clients will be in crisis and may be suicidal.
- Clients have not been open with each other and do not freely discuss sexual matters.

An example of common misinformation is that it is not unusual for men to misunderstand the cause of a nocturnal erection. Many will misattribute this response to having a full bladder. This misattribution undoubtedly developed because when men wake up at night to urinate, they often have erections, followed by detumescence as the man begins to "wake up." We have even heard physicians speak of "full-bladder erections," showing that this misunderstanding is widespread and not confined to less-educated people. It is interesting that most men do not see an inconsistency in their logic based on lack of erection during the daytime when they have to urinate.

Goals

Goals are the desired outcomes established before each session to give the assessment procedure a focus. At times, the goals have to be adjusted as information is learned to accommodate the needs of the patient. However, adhering closely to the goals will help make the therapy more efficient by helping to minimize sidetracking.

Examples of the goals you might set for the first session include the following:

- Establish rapport.
- Obtain a general description of sexual problems.
- Obtain a thorough psychosocial history.
- Obtain a description of other life concerns and current stressors.
- Determine whether sex therapy is appropriate for the patient/couple at this time.

With regard to the last-mentioned goal, no specific guidelines can help you in making this determination. Thus, a therapist should determine on a case-by-case basis whether working on a sexual problem will benefit a patient/couple. Certainly, if either partner is depressed and/or overly anxious, or if there is a great deal of anger, then it is more appropriate to address nonsexual issues first. In some cases, sexual difficulties may be insignificant in light of other problems. Furthermore, effective assessment and therapy require collaboration between both partners and the therapist that is compromised in the presence of couple hostility. Similarly, there may be very dysfunctional communication between partners that must be addressed before their sexual issues can be effectively confronted.

Process

"Process" is the term that describes the interaction between a patient and a therapist; this interaction can either facilitate or inhibit the assessment. When we use the term "process," we also mean to include the physical setting (Is it private? professional?), the therapist's appearance (competent, trustworthy) and presentation (well prepared, informed, calm, friendly, accepting), as well as the more common meanings of the term "process." It is clear that many clinicians feel uncomfortable dealing with sexual problems. Personal feelings of shock and embarrassment will often show through therapist attempts to be friendly and accepting. Mismanagement of these negative feelings could be divisive and create a barrier to effective therapy. If a therapist's feelings cannot be managed appropriately, then he or she should not be dealing with sexual problems. Patients readily discern embarrassment or incompetence—as did the patients we mentioned earlier.

Additional examples of process factors that can sabotage assessment (and subsequent therapy as well) include differences between the therapist and patients in terms of age, gender, and/or ethnicity; and erotic attractions or interpersonal repulsions between therapist and patient. With the exception of erotic attractions, other factors between therapist and patient

should be addressed openly in the assessment process. For example, a young male therapist may wish to address gender and age differences in the assessment of an elderly woman presenting with decreased sexual desire following onset of menopause. This may be approached as follows:

> "Mrs. Jones, you are here to discuss and obtain help for a sexual problem and I am wondering if talking to a younger male therapist about such matters makes you uncomfortable or even inhibited to do so? Talking about sexual matters to any stranger is often difficult for most people, but I wonder if you feel you may have a problem talking to me."

By presenting this issue for discussion, you acknowledge (and give the patient permission to express) a normal amount of discomfort or embarrassment regarding the discussion of sexual material. Also, you will ask the patient to express honestly whether his or her anxiety may interfere with the assessment or therapy process. Finally, by raising the topics of age and gender, you will have presented yourself as a sensitive and understanding therapist. If a patient expresses an unacceptable level of discomfort, then you should make every effort to refer the patient to a therapist whose characteristics may better serve him or her.

There may be other circumstances that require a referral to serve the patient best—for example, if you lack the technical expertise or the life experience to help a particular patient. As we discuss later, some clinicians may not feel comfortable or prepared to work with gay, lesbian, or bisexual patients. Alternatively, a younger therapist may not be able to fully appreciate the challenges faced by a widow as she tries to overcome continued attachment to her first husband while she attempts to build a relationship with a new partner. And, from time to time, gender matching of patient and therapist may be most appropriate. Under such circumstances, the ethically responsible decision is to refer the patient to a therapist who is better suited to his or her needs.

Finally, in some instances, you may have a strong attraction (or negative feelings) toward a patient. In such cases, we advise against disclosing your feelings to the patient; rather, refer him or her to another therapist. Each of us as therapists may have our own style in handling such situations, but generally you should tell the patient that you feel another therapist could better serve him or her.

Structure and Content

"Structure" and "content" refer to the ordering of questions to be asked, and the areas to be covered, respectively. In general, it is to the patient's

benefit for a therapist to get to the heart of the patient's concerns. Thus, spending several sessions "breaking the ice" or "establishing a relationship" is not warranted in most cases. (An exception to this general rule occurs when prior intimate or therapeutic relationships have been quite unstable; in such cases, it may be necessary to devote several sessions to establishing trust.) In all instances, it is useful to get a general sense of the patient's history, especially as it relates to his or her sexual adjustment.

The outline provided here is meant solely as a guide. This suggested order should not be followed blindly but should be modified depending upon the clinical circumstances. We do not advise following an invariant order of questions for all patients. Instead, the structure and content of the interview should reflect the needs of the patient. There are frequently crisis issues to which you must attend before sexual matters can be addressed. Or it may be important to allow a patient to digress beyond the usual structure, but only if the digression contributes ultimately to a better understanding of the patient or his or her problem.

With this recognition of the need to individualize the interview structure and content for each patient, we nevertheless suggest the following order that might be a useful beginning or "default" structure for your use:

1. Start with nonthreatening demographics (e.g., age, marital status, who lives in the household, current employment, educational background, address, telephone number).

2. Continue with the open-ended question "What brings you here today?" Notice how freely and comfortably the patient discusses sexual matters in general, and his or her particular difficulty. Use probes and directive comments to keep the patient's report on target. Once you reach a general impression concerning the scope of the sexual problem, then move on to the detailed chronological history.

3. Obtain a psychosexual and psychosocial history.

   a. *Childhood*. Ask about the family structure and experiences when the patient was a child. Also ask about social status, abuse or neglect, first sexual experience (upsetting or pleasant?), parents' relationship, alcohol and substance abuse, messages about sex, and any other information that emerges as potentially relevant.

   When asking about sexual abuse or trauma, we encourage you to follow the recommendation of Becker (1989), an expert in this area, who recommends that you ask patients whether they have ever been the recipients of *unwanted* sexual acts. Use of the word *unwanted* allows patients to report experiences that they might not reveal if asked about "rape" or "abuse." In this regard, mention that many women are reluctant to identify sexual violations committed by boyfriends, husbands,

and others who are known to them. We also wish to alert you to the potential importance of vicarious trauma experiences.

As reviewed in earlier chapters, it is now understood that child sexual abuse is a powerful cause of many adult disorders (Beitchman et al., 1992). Thus, we wish to stress the importance of assessing this history.

b. *Adolescence.* Inquire about relationships with peers, self-esteem and body image, dating, sexual experiences (both homosexual and heterosexual), menarche in females, success or failure in school, substance use, and any other information that emerges as potentially relevant. Check again for unwanted sexual experiences. We also ask about attendance at school dances. This question often identifies a person's social comfort and peer relationships.

c. *Adult.* Ask about significant relationships and events after age 20; try to address self-esteem, marriage/relationship history, sexual experiences, and so forth. Check again for unwanted sexual experiences. Inquire about any unusual sexual experiences, as well as psychiatric history or treatment.

d. *Current sexual functioning.* Acquire details regarding sexual and nonsexual experiences in the current relationship, recent changes in sexual functioning and/or satisfaction, flexibility in sexual attitudes and behaviors, extramarital affairs, strengths and weaknesses of the partner, likes and dislikes regarding the partner's sexual behavior, and so on.

4. Obtain a brief medical history.

a. Ask about significant childhood/teenage diseases, surgery, medical care, congenital disorders, and the like. Ask men and women about how they experienced secondary sex changes (particularly menarche, in the case of women).

b. Pay particular attention to the medical history after age 20; ask about any significant diseases, surgery, medical care, and so forth. Be sure to ask about the following: Has the patient received regular medical care? (If not, refer him or her to medical workup.) Is the patient currently taking prescribed medication? Is the patient currently being treated for any medical problems? Ask women about menstrual difficulties and, if appropriate, menopause.

c. A critically important task is to assess both partners in a couple for history of sexually transmitted diseases (STDs). During the past two decades, we have witnessed an unprecedented pandemic of STDs, especially HIV. Worldwide, estimates suggest that 36 million people now live with HIV/AIDS (amFAR, 2012). Other STDs are even more prevalent. For example, genital herpes currently affects 40 million U.S.

citizens, with an additional 500,000 cases occurring annually. Chlamydia affected approximately 1.4 million U.S. citizens in 2012 and is known to be the most common bacterial-like STD infection (Centers for Disease Control and Prevention, 2012). Such data require that sex therapists inquire about STD history and current status, and help their patients to avoid future infection. Anyone who is sexually active is at risk, regardless of sexual orientation, drug use, or medical history. You should ask each partner in a dyad separately about his or her history of STDs and testing for HIV. If the couple's history together is recent, or includes other partners, and if both partners have not been tested recently for HIV, it is wise to suggest that they use condoms during insertive sexual behavior until HIV testing has been completed. We advise this as a standard precaution to protect your patients against infection.

5. Be sensitive to potential covert issues. Ask whether there are any issues that the patient does not want discussed in front of his or her partner. What significant conflict exists (impressions of one's partner or hidden experiences)? *We believe strongly in creating an interview environment in which each partner can be assured of confidentiality.* Without separate confidential interviews, crucial information may remain hidden. For example, consider the case of Mr. and Mrs. Williams.

Mr. and Mrs. Williams, ages 56 and 54, respectively, had been married for 26 years; they had two college-age daughters. Both Mr. and Mrs. Williams were professionals with graduate degrees. At the first session, they both agreed that the problem was Mr. Williams's lack of sexual desire. In fact, the couple had not had sexual relations for about 10 years. Mrs. Williams was clearly very angry, although both partners expressed a desire to stay in the marriage. Following a discussion of the assessment structure and therapy process, Mr. Williams asked to stay for his individual assessment session while Mrs. Williams retired to the waiting room.

Mr. Williams expressed great relief at being able to talk to the therapist alone, confidentially. He revealed in this session that he had been using male homosexual magazines as a masturbatory outlet for a number of years. More recently, he had started visiting homosexual websites on the Internet. At the point of the assessment interview, he denied any actual sexual contact with males, although he had thought about it often.

Mr. Williams was not prepared to share the information about homosexuality with his wife because he felt for sure she would immediately leave the marriage. He also felt that his interest in homosexual stimulation was not a causative factor, because his lack of sexual interest in his wife began

years before his interest in male homosexual erotica. Obviously, this was a complicated case with many delicate issues. The important point of this case is that had separate interviews not been held, the therapist would never have known about the very important issue of Mr. Williams's use of erotic materials. Knowing this information was essential for developing an overall treatment strategy. This couple was also told at the onset that it may be best to deal with either person alone at times in order to work through specific issues. As it turned out, therapy did begin with individual therapy for Mr. Williams.

There are some issues that, although raised in individual meetings, must—ultimately—be addressed conjointly. An extreme example might be an instance in which one partner confides that he or she has a viral STD about which his or her partner does not know. Here, we would work with the infected partner to help him or her determine how best to share this information. This disclosure will often need to be done in session, and its meaning for the relationship will need to be processed. There is also the need to plan for treatment of the infected partner, and prevention of new infections in both partners.

In most cases, the infected partner agrees that such disclosure is appropriate but has been afraid (or not sure how) to disclose. This is where you can be very helpful, using problem solving, role plays, and rehearsal in individual meetings. If the infected person refuses to share this information with his or her partner, then you face an ethical dilemma. On the one hand, you have an obligation to honor the confidence of the infected person; on the other hand, you have the duty to warn the partner against the possibility of infection. Because of the complex and evolving legal and ethical opinions regarding your responsibilities under such circumstances, we advise you to consult with your state health department, professional colleagues, and organizations regarding the best way to resolve such a dilemma should it arise in an assessment. The circumstances surrounding such rare cases are unique and must be considered thoroughly.

6. Provide each patient with a second opportunity to reveal anything he or she thinks may be relevant. In this regard, we recommend ending the interview by asking "Is there anything else that you would like to tell me about your background that you feel bears on your sexual life?"

The second interview is with the other partner. We ask this partner whether anything has changed since the first interview, and whether the partner has discussed the first interview with him or her. The answers to these queries will yield information about a couple's interaction pattern, openness in communication, and ability to schedule time for important issues. It is also important to ask this partner whether there are any issues or questions that he or she would like addressed before the interview begins.

This open-ended approach allows the discussion of process issues (such as a patient's doubt about a therapist's qualifications) as well as important personal issues that may have an impact on the therapy (such as a patient's affair or a death in the family).

Once the open-ended issues are dealt with, you may move on to the interview proper, following the structure and content outline for the first interview.

CONJOINT INTERVIEW AND CASE FORMULATION: SESSION 3

The third interview normally includes both partners. (An exception to this pattern may occur if one individual's needs are so overwhelming that individual therapy is indicated prior to couple therapy, as in the earlier case example.) The interview with both partners should begin in an open-ended manner to determine what changes and conversations may have occurred since the last session. A couple's response to this approach is important diagnostically because it provides an understanding of how the couple approaches and discusses important problematic topics. You can observe which partner takes responsibility for what, and how effectively each person communicates his or her needs. Consider also that a couple may be overwhelmed with recently occurring problems or stressors, such as job loss or a death in the family. Obviously, it is important to acknowledge nonsexual issues that may preoccupy patients and distract them from the current focus of the assessment. The remainder of the third session should be spent providing your formulation, identifying treatment goals (sexual and nonsexual), outlining therapy plans, and explaining details regarding the initial stages of therapy. To further facilitate rapport, maximize therapy compliance, and avoid backsliding, you should ask each partner how he or she feels about the plan and what problems each anticipates as barriers to progress.

Elements of the third assessment session might be as follows:

Assumptions

As before, it is useful to begin with assumptions in the most helpful direction. For example, you may find it helpful to assume the following:

- The couple has not discussed previous interviews.
- The couple has trouble discussing sexual matters and is embarrassed.
- There may still be a crisis.
- Correct terminology is still not well understood.

- Sexual attitudes are rigid and conservative.
- Avoidance of sex will occur because of fear and discomfort.

These assumptions position the therapist to approach the third assessment session with caution to counteract a possible therapist-pleasing presentation on the part of the couple. Thus, although a couple may present as though "things seem better," the crisis most likely still exists and needs attention. Certainly, the therapist should not approach the couple pessimistically but should realistically approach all issues.

Goals

You should also establish goals for this session; possible goals include the following:

- Review your own observations and formulations.
- Invite the couple to identify inconsistencies between your observations and formulations and theirs.
- Outline and begin a therapy plan.
- Obtain the couple's commitment to follow the therapy plan by discussing potential compliance problems ahead of time.
- Encourage the couple to begin conceptualizing problem as learned and "situational," and discourage partners from blaming one another.

Process

Process issues continue to be important. Thus you may want to cover the following points:

- Ask the couple whether there were any developments since your last meeting.
- Ask the couple what they have discussed: Why or why not?
- Ask whether there are any doubts or issues to be discussed before therapy begins.
- Ask the couple whether there are any anticipated difficulties in participating in therapy with you as therapist. (Are there concerns regarding the therapist's gender, age, or race?)

Structure and Content

The third session may be ordered as follows:

1. After consideration of process issues, begin the interview by defining the problem, indicating possible contributing factors, and acknowledging that you will continue to collect information as therapy starts. Ask each partner to comment on and clarify any misunderstandings or disagreements.

2. Ask each partner to discuss his or her reaction to a sexual encounter when it is thought to be a failure.

3. Outline the therapy plan; if possible, try to discuss all stages of therapy. Emphasize, in detail, what the first stage will involve—this will establish hope. Be sure to ask the couple to identify any anticipated problems and to commit to the initial step (i.e., set a specific date and time for your next meeting).

For many patients, further assessment information will be needed, such as that gathered from psychological testing, psychophysiological assessment, and/or medical evaluation. If this is the case, then therapy instructions may have to be postponed until the assessment picture is completed. (Later in this chapter, we discuss the integration of interview data with information obtained from other methods.) It is very important to explain the nature of and need for further assessment, so that a patient does not get discouraged or frustrated.

The interview is the most common procedure for assessing sexual problems. Over the years, as our clinical sophistication and knowledge base have increased, the interview procedure for assessment of sexual problems has become more structured and standardized. Thus, today's interviewing methods yield more valuable information then ever before because we are more knowledgeable about the complexities of sexual functioning. The remainder of this chapter focuses on integrating multiple sources of information and recognizing special challenges to the assessment process

COMMON PERCEPTIONS AND REACTIONS TO SEXUAL PROBLEMS

We have found over the years that there are some common perceptions and reactions that each person in a couple goes through when a sexual problem is present. The person presenting with the sexual problem will often convey to the therapist that he or she believes that the problem is medical. It seems to be difficult for people to accept the possibility that their sexual problem is not medical since such an acceptance will imply willfulness on their part and inculcate blame. We have had many patients state, after learning that their sexual problem was not medical, that they wished that it was medi-

cal. Not only does a medical cause remove blame, but it is often mistakenly thought to be amenable to an easy treatment with a pill.

Individuals presenting with a sexual problem will also begin to avoid sexual encounters. Patients have told us "I don't want to fail" or "I don't want to disappoint my partner." In many cases, a person is also harboring the belief that his or her partner will leave him or her if sexual failure continues. Avoidance appears to be the lesser of two evils in some people's minds. Sexual failure also undermines a person's self-confidence more generally and can even sow seeds of gender doubt. "I am not a real man" or "I am not a real woman" are statements we have heard from some of our patients.

The partner of a person presenting with a sexual problem will often have an initial reaction of "My partner does not find me attractive." This is especially true of female partners in a heterosexual relationship when the male is presenting with ED. "Don't you find me attractive?" "Don't you love me?" "Are you interested in someone else?" "Are you having an affair?" These are all common statements we have heard from our patients. We routinely ask our patients how their partner reacted to their sexual problem and "What does your partner think is the cause of your sexual problem?" We often hear that the partner responded with one of the questions mentioned above.

Partners seem to go through three distinct phases in reaction to their mates' sexual problems. *Phase one* often involves an increase in sexual pursuit and seduction. When this does not work, *Phase two* sets in and is characterized by anger, blame, and a search for help. If the problem persists and help is not sought, *Phase three* evolves and is characterized by discouragement, numbing, loss of sexual interest, and an increased vulnerability to the attention of others.

The descriptions above of the perceptions and reactions of individuals presenting with a sexual problem and their partner's perceptions and reactions are common but certainly do not apply to all of our patients. We have certainly met many individuals and their partners who respond with compassion and informed understanding of the process and etiology of sexual dysfunction.

SELF-REPORT QUESTIONNAIRES

Although the clinical interview is the mainstay of the psychosocial assessment process, there is value in using some of the brief questionnaires that are available to supplement the assessment process. As previously mentioned, more specific mental health testing may be used for comorbid mental health problems, but in this section we would like to mention several common

brief instruments regularly used for the specific purpose of assessing sexual problems. Because of their brevity, they are easy to administer and can be used for diagnosis and for pre-/postassessment of treatment.

International Index of Erectile Function

The International Index of Erectile Function (IIEF; Rosen et al., 1997) is a 15-item self-report measure of erectile functioning that is psychometrically sound, sensitive to treatment changes, and available in 10 languages: Danish, Dutch, English (American, Australian, British), Finnish, French, German, Italian, Norwegian, Spanish, and Swedish. (Validation of the scale in Arabic, Chinese, and Portuguese, among others, is underway!) The IIEF has separate items for achieving and maintaining erections, and it assesses the ability to achieve erections in nonintercourse sexual activity. There is one item that asks about the respondent's confidence in being able to achieve and maintain an erection, a psychological dimension shown to be related to treatment outcome (Rosen, Leiblum, & Spector, 1994). The IIEF assesses current sexual functioning in five domains: erectile functioning, orgasmic functioning, sexual desire, intercourse satisfaction, and overall satisfaction. The internal consistency for each of the five domains measured by the IIEF has been established, and test–retest stability is also strong. All five domains, except the sexual desire domain, can discriminate between men with and without erectile problems. (We prefer the Sexual Desire Inventory [Spector, Carey, & Steinberg, 1996] for direct assessment of desire difficulties in men as well as women.) Based on outcome studies examining treatment of erectile disorder by sildenafil citrate, the sensitivity and specificity to treatment changes were demonstrated. Advantages of the IIEF are that it takes less than 15 minutes to complete, and it is comprehensive and easily scored. Assessment of other components associated with sexual function and of the relationship by the IIEF is limited. Another limitation of the IIEF is that it has only been validated with heterosexual patients, and that the standard instructions define sexual intercourse as "penile–vaginal penetration," making it less applicable to gay and bisexual men.

Sexual Health Inventory for Men

The Sexual Health Inventory for Men (SHIM; Rosen, Cappelleri, Smith, Lipsky, & Pena, 1999) was developed as an offshoot of the IIEF and like the original IIEF has been translated into more than 30 languages and is a widely used screening measure in clinical practice and a research tool for ED studies. The SHIM contains five items and each is rated on a scale of 0 to 5 or 1 to 5 (depending on the item) yielding a score from 1 to 25. The higher the score, the more impairment from ED. In our clinic, we use the

SHIM with every patient presenting with ED and it is employed as a repeat assessment measure after each treatment protocol is completed. It is acceptable to use the SHIM with heterosexual, gay, and bisexual men.

Female Sexual Function Index

The Female Sexual Function Index (FSFI; Rosen et al., 2000) is a 19-item scale for the assessment of female sexual function in the domains of satisfaction, desire, arousal (lubrication), orgasm, and pain/discomfort. The FSFI is easy to complete and is scored on a 0 to 5 or a 1 to 5 scale, depending on the item. This instrument is psychometrically valid and reliable and can be used in research and in clinical practice as a diagnostic tool and pre-/postmeasure of change.

INTEGRATING MULTIPLE DATA SOURCES INTO A COHERENT CASE FORMULATION

We mentioned at the beginning of this chapter that one of the goals of the assessment is to develop a coherent case formulation (i.e., a working hypothesis of the etiology of the problem). This formulation should relate all aspects of a patient's complaints to one another and explain why the individual has developed these difficulties. One purpose of this formulation is to aid you in the development of a treatment plan. A second purpose is to communicate to your patients that (1) their problem is an understandable one given their physiology, medical history, life experiences, and so forth (i.e., they are not crazy or perverted); (2) there is reason for hope and optimism; and (3) you have a conceptual "road map" and rationale upon which to build a therapeutic plan. Finally, developing a case formulation allows you to check with the patient to see whether you have obtained all necessary information, and whether the information that you have is correct.

One of the more challenging aspects of sex therapy is integrating multiple levels of influence (i.e., biological, psychological, dyadic, cultural) into a coherent case formulation. Despite its difficulty, a biopsychosocial case formulation captures the richness of sexual function and dysfunction. Patients are more likely to agree to try a psychosocial approach if you recognize that biological causes are relevant and all contributing factors will be dealt with. A patient is also more likely to agree to try a psychosocial approach if you inquire about and recognize specific dyadic and sociocultural influences. You need to be sensitive to specific rituals and habits that a couple has established, as well as to ethnic, cultural, or religious traditions.

Your case formulation should include biological, psychological, and social areas even if you believe that one area does not contribute to the

problem at the moment. It is difficult to predict the future, and you will have laid the groundwork should additional information become available and/or future developments occur. Moreover, this comprehensive approach to case formulation will give the patient confidence that you have considered all possibilities. Indirectly, you communicate to the patient that he or she should also think about the problem in a multifaceted, biopsychosocial framework.

To illustrate how you might present your information to a couple, we provide the following script based upon a composite of cases.

"Mr. and Mrs. Anthony, I want to use this session to review all of the information I have gathered and outline for you a possible treatment plan. The problem that you are concerned about is Mr. Anthony's difficulty with obtaining erections. This, of course, is very troubling because you both expressed a strong desire to have children.

"I want to point out some very positive findings in your situation. You both have expressed a very strong attraction and desire for each other and there do not appear to be any serious marital conflicts. Furthermore, the results of your medical examination, Mr. Anthony, are completely normal. There do not appear to be any medical factors complicating the picture. I believe that Dr. Jones reassured you that the medication you are taking for your skin problem is not causing the problem associated with erections. Even though your problem does not appear to be medical in nature, we can discuss the use of medication (PDE-5 inhibitors: Viagra, Levitra, Stendra, and Cialis) as a possible adjunct to the other strategies we will discuss. The intention is not to use such medication every time you have sex but to merely help get things started and build your confidence.

"In my assessment of both of you, I have covered a lot of possible factors that can cause sexual problems. While most of the areas we reviewed did not seem to apply to your situation, we did identify several possible important factors:

"First, both of you work a great many hours during the week and, because Mr. Anthony has a long commute, he does not get home until very late. You both agree that sex during the week is very difficult because there is little time together. Your weekends seem to be equally busy and both of you feel you need more relaxed, fun time together. Consequently, one important area we need to look at is how to create more priority time for you as a couple.

"A second possible factor is Mr. Anthony's difficulty in leaving his work even when he is home. Mr. Anthony, you reported that your mind is always problem solving and thinking of many issues. In fact, you said it is difficult for you to relax even when you do go on vaca-

tion. When it comes to sex, you said you have difficulty turning off your mind and very often you worry about work, finances, and other nonsexual matters. This style of thinking is most likely interfering with sex and is something we should work on in therapy.

"Finally, you seem to worry about sexual performance even when you are able to shut off your other worries. You worry about obtaining and maintaining your erection during sexual activity and you worry about how your wife will react if you have difficulty with erections. So, overall, I am suggesting that there are three factors that together appear to be causing and maintaining the erection difficulty. The first factor involves the lack of time combined with exhaustion resulting from working such long hours; this factor leaves you little time to develop conditions conducive to a relaxing and fulfilling sex life. The second factor involves a style of thinking that is constantly problem solving. While this style may actually help you be successful in your job, it tends to interfere with sex. A third and final area of concern is sexual performance anxiety. Sex works best when a person enjoys sexual thoughts and sensations in the moment and does not focus on the outcome. [At this point, the therapist should pause and ask how each person feels about the formulation and ask if either partner feels anything has been left out or not considered. Following any discussion of the formulation, the therapist then outlines the specific strategies for addressing each identified treatment issue.]

"If you agree that these factors do appear to be responsible, at least in part, for the erection concerns, here's how I'd suggest we proceed. First, I think we need to work together to protect time to invest in your relationship, when both of you feel that you can truly relax and be there for each other. We will need to review other commitments and be creative in time management. I have some brief readings on the matter of time management that I'd like each of you to read in advance of our discussion.

"Second, I'd like to work individually with you, Mr. Anthony, to help you to manage your thinking about work in a way that works better for you. We will do some stress management work around physical relaxation and elimination of unwanted thoughts. I will ask you to practice a stress management approach that is comfortable for you, such as relaxation exercises, yoga, or meditation, depending on your preferences. I think you will enjoy this, and see benefits in other aspects of your life as well.

"When we have completed the time and stress management efforts, which should not take too long, we can focus on specific sexual exercises that I will ask you to complete in the privacy of your home. We will proceed through a series of steps, at a pace that is comfort-

able for both of you, to enrich your sexual life together. The exercises will be enjoyable and, given all the positive things you have going for you, I am optimistic that these exercises will help to make your sexual experiences more rewarding for you both.

"Does this plan make sense to you both?"

The above review illustrates how we try to integrate biological, psychological, and social factors for a particular case. The steps involved in presenting a formulation include the following:

1. Review the presenting problem, including normalizing the problem and educating the patient/couple as you go.
2. Review the patient's/couple's strengths in the biological, psychological, and social domains.
3. Identify the factors that appear to be responsible for the problem's development and maintenance; this is the core of the formulation.
4. Invite feedback from the patient/couple regarding your formulation, including additional information that confirms or challenges it. Be careful not to encourage a debate on the matter, and acknowledge that the formulation is meant to serve as a heuristic guide rather than as an exact factual account.
5. Outline the specific treatment components for addressing the causal factors, especially the maintaining factors associated with the dysfunction.

In general, we find that this approach gives the patient(s) confidence that you have considered all possibilities, and that you are not just providing a "packaged" treatment program. Instead, this approach makes clear to patient(s) that a specialized, customized treatment is adopted.

SPECIAL CONSIDERATIONS IN ASSESSMENT

The assessment process is not without its pitfalls, potholes, and problems. We have already alluded to the technical skills, costs, and some obstacles to conducting a state-of-the-science assessment. We now turn our attention to more prosaic challenges to the assessment process.

The Uncooperative Partner

In a small number of our cases, a patient will enter therapy without the full cooperation of his or her partner. Some of these patients have partners who are reported to be shy but cooperative; in other cases, the partner believes that the problem is the patient's and refuses to participate. This

always presents a difficult situation and one in which you can never be sure whether you have all the pertinent facts. To help an uncooperative partner become engaged in therapy you can suggest talking to the partner by phone. If he or she still refuses, then you can suggest reading material that is pertinent to the problem.

Crucial components of therapeutic change (e.g., communicating effectively, cognitive restructuring, and dispelling blame) can almost never be achieved when one partner refuses to participate. This is especially true when the uncooperative partner is purported to be angry and blaming. You can, of course, offer some therapeutic benefit to the participating patient by providing etiological explanations and information, clearing up misunderstandings, putting the problem in perspective, and outlining strategies for change. However, you must also describe the limitations of therapy and try not to shift blame or fuel anger toward the absent partner. The end result of therapy is often a patient who has an improved understanding of the problem and feels better about him- or herself but still has a dysfunctional relationship with his or her partner.

Gay, Lesbian, and Bisexual Patients

Single gay, lesbian, and bisexual (GLB) patients or couples can usually be assessed in the same way that we suggest for heterosexual patients or couples. GLB patients who are comfortable with their sexual orientation are likely to present with sexual dysfunction concerns similar to those of heterosexual patients.

There are several therapeutic issues that can cause unique distress for GLB patients. First, GLB patients who do not yet accept or feel comfortable with their sexual orientation may benefit from preliminary work dealing with common issues such as various forms of discrimination, internalized homophobia, and self-damaging behavior (e.g., alcohol or other drug abuse; Shires & Miller, 1998). Second, GLB patients must navigate a less well-structured and patterned sexual world. The stereotypical gender and sexual roles that are normative may make less sense to them than they do for the heterosexual majority on whom such norms are based (Behrendt & George, 1995; Fassinger & Morrow, 1995). Third, in the United States, gay and bisexual men have been more likely to be infected with HIV; this raises concerns about mourning previous partners, secondary prevention, and access to health care and related issues. Although HIV is a threat to all sexually active people, regardless of their sexual orientation, the epidemiology of HIV in the United States (and most of the developed world) reveals that gay men have been disproportionately affected.

Because we cannot provide either a comprehensive review of GLB issues, or specialized coverage of the clinical approaches that have proven most effective, we recommend further reading for therapists who intend to

work extensively with GLB patients (e.g., Behrendt & George, 1995; Coleman & Rosser, 1996; Fassinger & Morrow, 1995; Friedman & Downey, 1994; Herbert, 1996). As a final point, we wish to emphasize that if you are heterosexual and are uncomfortable treating GLB patients, then you should refer such patients to another therapist. Also, if a GLB patient is uncomfortable with you, their therapist, being heterosexual, then a referral to a GLB therapist may also be a good idea. We would be inclined to discuss patients' concerns but would, in the end, accept patients' preferences.

Single Patients without Partners

Patients without partners who are experiencing sexual dysfunction problems may require a few special considerations; in general, however, most of what has been discussed is applicable to these patients. It is common for a single patient to enter therapy after having experienced a "sexual failure." For men, this may have been an experience of premature ejaculation or erection failure, whereas for women this is likely to have been vaginismus, dyspareunia, or loss of desire. Regardless of the nature of the problem, single patients are likely to enter therapy with low self-esteem, sexual insecurities, and avoidance of social interactions. We try to be sensitive to these likely areas of concern and spend more time in identifying barriers that may impede social interactions.

Some single patients offer to bring in a casual partner to help with the therapy process. Our general approach is to allow a partner to participate only if there is a genuine commitment. The reason for this is to protect the patient, because assessment and therapy require the revelation and open discussion of vulnerabilities and intimacies that the patient may later regret having discussed. We have had some occasions when married patients offered to bring in lovers rather than their marriage partners. This situation presents obvious ethical concerns. We counsel patients on the pros and cons of legal separation and divorce. If a patient chooses to take no action, then the limitations and value of therapy must be fully discussed with the patient.

Patients Who Are Abusing Alcohol or Other Drugs

A great deal has been written about both the physical and psychological impact of chronic alcoholism on sexual functioning (O'Farrell, 1990; Wilson, 1981). It is well documented that alcoholic men and women experience a high prevalence of sexual problems (e.g., Jensen, 1984; Klassen & Wilsnack, 1986; O'Farrell, 1990). Male alcoholics are susceptible to low desire and ED, whereas female alcoholics are at increased risk for low desire, orgasmic dysfunction, and vaginismus.

Although it is tempting to try to help patients with substance use disorders to improve their sexual functioning, we have learned that this is extremely difficult. We advise that you not treat the sexual problem if problem drinking or drug use is ongoing. Substance abusers should be referred for substance abuse treatment before sex therapy is attempted.

Patients with Atypical Sexual Behavior

We have encountered a number of sexual dysfunction cases with underlying issues of atypical sexual behavior. The sexual dysfunction is usually identified as HSDD or ED in males or FSIAD in females; and, in many cases the atypical sexual interests are not identified until there is a very detailed evaluation of the specific stimuli or conditions that stimulate sexual arousal. Males are overwhelmingly more likely to be at risk for atypical sexual interests than females. The most direct route to understanding a male's sexual interest is to explore the sexual fantasies or visual stimuli that he uses during masturbation. The content of sexual stimuli that a person explores on the Internet will also be very revealing. We have encountered cases in which there are very common themes such as bondage or sadomasochism and in other cases there have been very unusual sexual fantasies. For example, in one case, a male presenting with ED was sexually aroused by women who wore Mardi Gras masks. Initially, his wife went along with this desire and considered it playful but, as time went on, the notion of playfulness was eclipsed by feelings of objectification and anger.

In another case, a married woman in her 60s presented with low desire. It turned out, however, that her low desire was associated with her husband's insistence that she recount her past sexual experiences with other men whenever she and her husband had sex. Her husband's pressure for details became a strong disincentive for sex.

In these cases, it is important to assess to what extent the atypical sexual interests are essential for arousal. In some cases, the atypical interests meet the criteria for paraphilia, while in other cases the interests are arousing but not essential. The challenge is to evaluate to what extent a couple can maintain a sexual relationship and accommodate the atypical behavior. Atypical sexual interests are unlikely to disappear but in many cases the atypical interests can be utilized intermittently with a partner's consent in a manner that is acceptable and not aversive.

Patients with Gender Identity Problems

Gender identity is similar to sexual orientation in that there is a *continuum* of gender dysphoria feelings. On one end of the continuum are individuals who have never had thoughts of identifying as a person of their non-

biological gender (cisgender); while on the other end of the continuum are individuals who have always thought of themselves as being of their non-biological gender and in the wrong body (transgender). These latter individuals experience extreme gender dysphoria and may be candidates for sex reassignment surgery. In addition to the concept of a continuum, the other similarity with sexual orientation is that some individuals with some degree of gender dysphoria get married because of family or societal pressures. In such cases, it is not at all unusual for sexual dysfunction to emerge as HSDD, ED, or FSIAD. Most therapists do not have the knowledge base or expertise to deal with cases of gender dysphoria, so these cases should be referred to experts in the area. Since hormone therapy and sex reassignment surgery involve irreversible changes to biologically normal individuals, extremely detailed and prolonged assessment is conducted to help individuals make informed decisions about the best course of action to take for their situation. Therapists wishing to gain more clinical knowledge about gender identity assessment and treatment should consult the website of the World Professional Association for Transgender Health *(www.wpath.org)* and read the "Standards of Care."

It is important for clinicians treating individuals with gender identity concerns to understand that sexual orientation is a separate dimension from gender identity. Consequently, a "biological male" may be sexually attracted to either males or females. Such a person would therefore be considered lesbian if involved with a female partner. One of us (J. P. W.) is currently treating a "trans" couple in which both partners are biological females but conceptualize their relationship as gay males. Both partners have had mastectomy with planned genital surgery. This is just one of many such case examples that underscores the importance of assessing the separate continua of sexual orientation and gender identity.

CONCLUDING COMMENTS

The assessment procedure necessary for accurate diagnosis of sexual dysfunction has continued to become more complex in recent years. We now understand that most sexual problems present with an interplay of biological and psychosocial factors, and demand a wide range of expert diagnostic input. This can be an expensive and, at times, a long process; we look forward to more streamlining in the future especially because psychological and medical cooperation has grown stronger.

A comprehensive assessment interview cannot be separated from therapy. Within the assessment process, a patient's attitudes are often challenged, new information is learned, and misunderstandings are corrected. By asking patients about various factors that influence their sexual response,

you are helping them to view the sexual problem as a state rather than as an unchangeable trait. This conceptualization is important to restore optimism to the patient and to his or her partner. Similarly therapeutic is the reduction or removal of blame for the sexual problem. Assessment solicits information from each partner; thus it helps redirect blame and guilt, and focuses the couple's energies on solving problems. Assessment also facilitates the breakdown of barriers to communication. This process is begun during the assessment because the patient is asked to discuss details of his or her own sexual behavior and details of his or her partner's sexual behavior. Clients observe you, the therapist, discussing sexual matters in an open and nonthreatening manner, and this discussion models effective communication.

Thus, through the assessment process, couples are exposed to an appropriate communication style and are encouraged to discuss sexual matters in a constructive rather than a destructive or avoidant manner. It is not surprising that many couples report positive change in their attitudes, and in some cases in actual sexual behavior, following assessment, before therapy proper even begins.

PART III

Treatment of Sexual Dysfunction

Once the assessment is completed, the therapist develops the treatment strategy and shares it with the patient and the patient's partner (if available). The therapist should invite the patient and partner to comment on the plan, ask questions, and express support for or potential problems with the plan. The general goals of treatment should be identified and the specific medical and psychosocial strategies should be laid out concretely and in detail for the patient. The assessment may have identified the etiology of the sexual problem to be purely biological, purely psychosocial, or a mixture of biological and psychosocial factors. Similarly, the treatment strategy may involve purely biological approaches, purely psychosocial approaches, or a mixture of biological and psychosocial approaches. Keep in mind, however, that just because the etiology of a problem is purely biological or purely psychosocial, that does not mean that the treatment strategy has to be purely biological or purely psychosocial. For example, a young male presenting with a problem with ED that is purely psychogenic may benefit from a treatment strategy using a PDE-5 inhibitor as well as psychotherapy.

One other consideration in developing a treatment protocol is to determine which problem should be treated first when more than one problem is identified. In many cases, more than one problem can be treated at the same time. However, there are certainly cases in which certain problems must be treated before treating other problems. There may be medical problems, relationship problems, or mental health problems that must be addressed before directly treating a sexual problem. For example, it would be difficult to treat a woman's lack of sexual desire if she is struggling with drug addiction. A significant comorbid problem must be resolved first in order to establish a stable baseline to focus on the sexual problem.

13

Biomedical Treatment

In this chapter, we discuss the medical treatment of men and women presenting with sexual problems. The medical treatment strategy will identify the *common* ingredients for treatment that males and females can expect in most cases of sexual dysfunction. In addition, we will describe the medical protocol and procedures for addressing *specific* sexual problems.

COMMON MEDICAL STRATEGIES FOR TREATMENT OF MEN AND WOMEN

Providing Information

Providing accurate information and dispelling myths and misunderstandings is a valuable role that all physicians play in treating sexual problems. Many people find the wide availability of medical information on the Internet helpful, but such information may also add to confusion as people try to sort out fact from fiction. Our physicians in the Men's Health Center encounter examples of misunderstandings almost daily. The most common misunderstandings are related to patient's medications or medical procedures that they have undergone and the attribution of these treatments to the cause of their sexual dysfunction. In addition to the misunderstanding of the side effects of prescribed medications, some patients have also attributed their sexual dysfunction to over-the-counter medications they are taking, such as cough syrup. It is always helpful to patients to have their physician clarify the true causes of sexual dysfunction so that necessary and helpful medications are not discontinued because of unfounded fears.

We have also encountered misunderstandings as to the cause of certain diseases. One of our urologists recently examined a male patient who presented with a bend in his penis that was diagnosed as Peyronie's disease.

The patient's wife was gravely concerned that her husband had cheated on her and "caught" this condition from having sex with another woman. The urologist explained that Peyronie's disease was a connective tissue disorder involving the growth of fibrous plaques in the soft tissue of the penis and that it was not transmittable. This helped allay the woman's fears of catching a sexually transmitted disease.

Physician's (as well as nonphysicians) are also in an important position to provide normative information about sexual practices. Patients often bring to the physician questions about their own sexual practices and wonder how they compare to others. Questions about the frequency of sex, duration of sex, normality of masturbation, and attractions to people other than their partner are just a few of the common inquiries that physicians encounter. In most cases, people are relieved to learn that what they thought was problematic is actually within the norms of most people's experiences.

Treating Interfering Medical Problems

Very often in the medical assessment, specific medical conditions are identified that are either directly or indirectly contributing to a person's sexual dysfunction. The physician will either treat the medical condition him- or herself or refer the patient to a medical specialist for treatment. The decision to refer is based on the primary care physician's expertise and whether or not there is a need for specialized assessment, treatment, and monitoring of a particular medical disease. The most common interfering medical conditions are diabetes, hypogonadism, cardiovascular diseases, neurological diseases, metabolic syndrome, endometriosis, prostatitis, and various cancers. Physicians may also identify and treat psychiatric conditions such as depression.

Pharmacological Treatment

Today's physician has a large number of pharmacological agents that he or she may use either in conjunction with other treatment efforts or as treatment strategies alone depending on the type and complexity of the sexual dysfunction problem being treated. It may be helpful to think of pharmacological interventions as falling roughly into four categories:

1. *Specific disease treatment*. This category would include the use of any pharmacological agent (antibiotics, anti-Parkinsonian medication, pain medication, etc.) that is used to treat a disease or medical condition that directly or indirectly adversely impacts on sexual functioning in men and women.

2. *Treatment of hormonal imbalance.* Hypogonadism in men presenting with ED or problems with low sexual desire is extremely common (Mueleman & van Lankveld, 2005) and in most cases is treatable with hormone therapy. Women presenting with estrogen deficiency causing vaginal discomfort may also be treated hormonally but at this time there is no hormonal treatment for low desire in women that is FDA-approved.

3. *Enhancing sexual performance.* For men, sexual arousal can be improved by means of a number of pharmacological agents that increase blood flow to the penis. These agents include sildenafil (Viagra), tadalafil (Cialis), vardenafil (Levitra), vardenafil HCl (Staxyn), and avanafil (Stendra) that are collectively known as PDE-5 inhibitors. There are also new PDE-5 inhibitors in development (Wang et al., 2013) but all target male arousal and not female arousal.

4. *Inhibiting sexual performance.* There are a number of pharmacological agents that can be used "off label" to help men with premature ejaculation. These medications include SSRIs and some pain medications such as Tramadol that have been developed for other purposes but whose side effects slow down ejaculation.

SPECIFIC BIOMEDICAL TREATMENT FOR MEN WITH HYPOACTIVE DESIRE DISORDER AND ERECTILE DYSFUNCTION

Hypogonadism is the medical term that describes diminished activity of the gonads (testes in males and ovaries in females) and can cause fertility problems as well as developmental problems in males and females. For males, hypogonadism results in low testosterone production and also causes low sexual desire and erection difficulty. Hypogonadism can be classified as *primary* if it is a result of impaired testicular function or it can be *secondary* (or central) if it is a result of impairment of hypothalamic or pituitary function. If testosterone levels are determined to be *primary*, then testosterone replacement therapy (TRT) will usually be prescribed (Jacob, 2011; Khera et al., 2011). Testosterone may be delivered through the skin as a patch or gel, by injections, or by slow-release pellets (Testopel) surgically placed under the skin in the buttocks. If, on the other hand, low testosterone is found to be *secondary,* then it may be treated by the drug clomifene (trademarked as Androxal or Clomid; Ioannidou-Kadis, Wright, Neely, & Quinton, 2006).

The *metabolic syndrome* was recognized by the World Health Organization in 1999 and is defined by general obesity, abdominal obesity, dyslipidemia, hypertension, and hyperglycemia. An excellent review of the metabolic syndrome and its causal relationship to men's sexual health is

provided by Meuleman (2011). The metabolic syndrome is a combination of conditions that together contribute to an increased risk for cardiovascular disease, diabetes, and hypogonadism and impaired sexual function in males through decreased blood flow to the penis, resulting in ED. Men diagnosed with the metabolic syndrome also commonly complain of low sexual desire. The metabolic syndrome is a condition that once diagnosed must be treated by a biopsychosocial approach of lifestyle changes including increasing exercise, changing to a healthy diet, controlling cholesterol levels, and TRT (Glina, Sharlip, & Hellstrom, 2013).

The medical *protocol for treating ED* involves increasingly invasive strategies starting with the least invasive procedure first, the use of PDE-5 inhibitors. This protocol can be illustrated as follows:

1. PDE-5 inhibitors (Viagra, Levitra, Staxyn, Stendra, or Cialis) (2-year shelf life)
2. Vacuum devices
3. Vasoactive gels inserted into the urethra (stored refrigerated 3 months)
4. Intracavernosal injections (ICIs) of vasodilators (stored frozen up to 6 months; stored refrigerated 1 month)
5. Combinations of the above strategies
6. Penile implant surgery

PDE-5 Inhibitors

To understand how PDE-5 inhibitors work, it is helpful to review the physiological mechanism of erection of the penis. The arousal process starts with sexual stimulation, which releases nitric oxide (NO) in the corpus cavernosum of the penis. NO then activates the enzyme guanylate cyclase, which results in increased levels of cyclic guanosine monophosphate (cGMP). cGMP relaxes smooth muscle and allows an inflow of blood, which results in an erection. There is, however, another enzyme in the penis—PDE-5—that works against the cGMP. The degradation of cGMP will return the erection to its flaccid state. Normally, when there is sufficient sexual arousal, there is enough NO to compensate for the degradation of cGMP. In men with performance anxiety that causes ED, the PDE-5 overwhelms the cGMP and the erection is lost. Viagra, Levitra, and Cialis all work in the same manner by inhibiting the PDE-5 enzyme and allowing a sufficient release of NO to maintain an erection.

This process can be illustrated as follows:

1. Sex stimulation releases NO in the penis.
2. NO stimulates the production of cGMP, which relaxes smooth muscle, increases blood flow, and produces an erection.

3. In normal erections, there is sufficient NO to compensate for the degrading effects of PDE-5 on cGMP.
4. In men with ED, insufficient NO allows the PDE-5 to overwhelm the cGMP and the erection is lost.
5. Viagra, Levitra, Stendra, Staxyn, and Cialis are PDE-5 inhibitors and therefore diminish the degrading effects of PDE-5 and consequently increase the amount of NO, which supports the production of an erection.

When PDE-5 inhibitors are prescribed, we generally ask a man to test out the use of the medication during private masturbation or with their partner. Masturbation is suggested only if a man is comfortable with this self-stimulation, has access to erotic materials, and is able to masturbate in privacy in a relaxed manner. Private masturbation usually removes the influence of performance anxiety that may be inherent in a relationship with a partner and it also allows a man to determine if there are any interfering side effects. The most common side effects are headaches, nasal congestion, facial flushing, blue vision, and muscle aches. All of these side effects are transitory and benign. PDE-5 inhibitors also lower blood pressure, and therefore are used with caution or not at all if a patient is taking other medications to lower blood pressure. It is specifically contraindicated in men being treated for cardiac problems who are taking nitrate-based medications. While most men experience no side effects, in some cases the side effects are so severe that they can interfere with sex. If side effects are disruptive, a physician can suggest changing medication or dosage level. In the case of headaches, aspirin can be taken prophylactally before taking the PDE-5 to prevent the headache. In spite of the fact that all five PDE-5 inhibitors share the same mechanism of action, there are idiosyncratic responses and some men may find changing from one medication to another produces a different response.

Vacuum Devices

Vacuum devices are glass or plastic cylinders that are placed over the penis and create a seal at the base of the penis and then pumped to create a vacuum in the cylinder. The vacuum in the cylinder draws blood into the penis and produces an erection. An elasticized ring is then placed at the base of the penis to hold in the blood and maintain the erection. Men complain that this can be uncomfortable and the penis must be guided by hand to help with penetration because the penis will otherwise bend at the ring.

Vasoactive Gels

If PDE-5 inhibitors do not work, the next level of intervention is the use of vasoactive gels that can be inserted into the urethra with a special appli-

cator. The gels are compounded and can be produced in different dosage levels and with different mixtures of various vasodilators: alprostadil, prostaglandin E1, phentolamine, and papavarine. Some men experiences severe burning sensations and the medications must be adjusted to reduce the uncomfortable sensations. The gels have a shelf life of about 3 months and must be refrigerated. The gels usually are effective within 15 minutes and last up to an hour or more depending on dosage level. Care has to be taken not to overdose, which can cause priapism.

Intracavernosal Injections

ICIs also use the same array of vasodilators but are injected with a small needle directly into the side of the penis into the corpus cavernosum. The medication also must be refrigerated and has a shelf life of about 1 month. ICIs are usually effective within 15 minutes and may last up to an hour depending on the dosage. As with the gels, care must be taken not to overdose and cause priapism. Many men are hesitant to use gels and ICIs because of the necessary loss of spontaneity and discomfort with the procedures.

Combination Strategies

In some cases, men benefit from a combination of vasodilators and PDE-5 inhibitors. This is almost always only in cases where there is significant contributions of medical factors contributing to the ED.

Penile Implant Surgery

The surgical implant of a penile prosthesis was first developed in 1973 and is considered the last resort of ED treatment and is usually considered only when other less invasive procedures have been tried and failed. There are two main types of penile prostheses available: the inflatable prosthesis and semirigid malleable rods. The inflatable prosthesis consists of two inflatable cylinders that are placed in the two corpracavernosa of the penis. The inflatable cylinders are attached by tubing to a saline reservoir placed next to the bladder and a pumping device placed in the scrotum. Erection is achieved and then returned to a flaccid state by the pumping action of the scrotal pump. The semirigid malleable rods are also placed in the two corpracavernosa of the penis without any other tubing or devices. Erection is achieved by manually bending the penis into position and then manually bending the penis down. Both devices provide sufficient rigidity for penetration and men with the penile prostheses will be able to experience full sensations and orgasm.

Besides risks of infection inherent in any surgical procedure, a small percentage of men also experience equipment failure, and in some rare cases actual erosion of the device through the penis tissue and skin. There is also a shortening of the length of the penis that is upsetting to some men.

SPECIFIC BIOMEDICAL TREATMENT FOR MEN WITH PREMATURE (EARLY) EJACULATION

The common misunderstandings about what defines premature (early) ejaculation were described in Chapter 5. Treatment of premature (early) ejaculation benefits primarily from normative information from the physician. In cases when men do meet the clinical definition of premature (early) ejaculation, physicians often prescribe medication "off label" in which the side effects can be used to physiologically slow down the orgasmic/ejaculation process. SSRIs are widely used in the treatment of premature (early) ejaculation. This can be done on a PRN basis or on a continuous use basis. Research has generally supported that the use of SSRIs on a continuous basis is more effective than using a PRN (as needed) strategy (Waldinger, 2007). Another common medication used is Tramadol, which is normally prescribed for pain management.

Another treatment strategy for premature (early) ejaculation is the use of Promescent which is an anesthetizing spray which can be bought over the counter. Promescent does not adversely affect the partner receiving penetration.

SPECIFIC BIOMEDICAL TREATMENT FOR WOMEN

Female Sexual Interest/Arousal Disorder

Since the success of Viagra in 1996 and the subsequent success of Cialis and Levitra for men, there has been a search to find a comparable drug to help women experiencing sexual arousal or desire problems. Pfizer Pharmaceutical attempted clinical research trials of Viagra for women in hopes of capturing the large market of females complaining of sexual dysfunction. Their efforts, however, were abandoned in 2004 when insufficient numbers of women presenting with sexual arousal disorder were enrolled in the multisite study. The new classification in DSM-5 has, in fact, combined the former diagnoses of hypoactive sexual desire disorder and female sexual arousal disorder into the single category of sexual interest/arousal disorder in women. To some extent, this new classification reflects the rarity of female sexual arousal disorder in premenopausal women. The quest for a drug for women has subsequently focused on desire rather than arousal.

Two potential pharmaceutical agents have been under investigation for affecting female sexual desire: bremelanotide and flibanserin. Neither of these agents has yet to be approved by the FDA but both have been presented by respective pharmaceutical companies as promising (Palatin Technologies is developing bremelanotide and Sprout Pharmaceuticals is developing flibanserin). Efficacy of the positive impact of these drugs is based on the subjective measure of increases in "satisfying sexual events." Flibanserin works by increasing levels of the neurotransmitters dopamine and norepinephrine while reducing serotonin, but to date no studies measure changes in brain chemistry to support the subjective measures.

Genito-Pelvic Pain/Penetration Disorder

There are certainly a wide availability of various lubricants that women can be advised to use who are experiencing painful or uncomfortable penetration when the problem is lack of lubrication and vaginal dryness. Perhaps because there are so many lubricants available, it may be a bit daunting for women to know exactly which lubricant to use. Further, most brands of lubricants do not advertise widely and many are not available in the neighborhood drug store, so patients often have limited knowledge about lubricants.

Oil-based lubricants such as massage oils, baby oil, Vaseline, and hand cream can stain sheets and are not safe for use with condoms, as they can destroy latex. As such, we do not recommend their use as sexual lubricants. Some of the more common, easily available lubricants, such as K-Y Jelly and Astroglide, are water based but may contain paraben and glycerin. While these lubricants have the advantage of not staining sheets, they are short lasting, may becoming "sticky," and need to be reapplied during sexual activity. In addition, paraben and glycerin may contribute to yeast infections in women with type II diabetes. Other water-based lubricants exist that do not contain paraben and glycerin. These lubricants are less likely to become sticky during use and may be safer for women prone to yeast infections. Astroglide now has a new paraben- and glycerin-free formula available for purchase. Some other popular brand names of paraben and glycerin-free water-based lubricants include Liquid Silk, Sliquid, and Slippery Stuff. Many newer lubricants are silicone-based. Silicon-based lubricants have the advantage of being the most slippery, and staying slippery the longest. For this reason, they are often our top recommendation for women with sexual pain. However, these lubricants are flammable—so it is important to warn patients not to put them next to the bedside candle they may be using for ambiance. Some silicone-based lubricants include Pink, Eros, Wet Platinum, and Gun Oil. Advice on which lubricant to use can also be sought from a woman's primary care doctor, gynecologist, or nurse

practitioner. The brand names we list here are not exhaustive and are not meant to serve as specific product endorsements. Rather, they are meant to assist you in understanding that not all lubricants are the same and that some may work better than others for specific couples and specific needs. We often recommend that patients purchase small sizes of more than one of these lubricants, so that they can see what works best for them. Most of these lubricants are available to purchase over the Internet. Further, though lubricants are recommended for women with pain and penetration problems, we often also recommend the use of lubricants for both men and women with arousal and orgasm complaints. For gay and straight patients engaging in anal intercourse, the use of a good lubricant is a must.

Women with problems of penetration can be helped by working with their gynecologist or with a physical therapist who specializes in helping women to achieve comfortable penetration. Treatment involves the use of a set of dilators of increasing diameter. Practice inserting the dilators can be achieved at home as well as in the gynecologist's or physical therapist's office. Dilators can be purchased online (see *www.vaginismus.com/products/dilator_set?gclid=CLOwgtDilbwCFe87Mgod8AgA7Q*).

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Psychosocial Treatment

DETERMINING THE EXISTENCE OF COMORBID CONDITIONS

The psychosocial treatment of men and women experiencing sexual dysfunction will be structured based on the assessment findings and will be coordinated with the biomedical treatment. The first consideration, however, should be to determine if any *comorbid* conditions exist that *must* be addressed and treated before directly focusing on sexual functioning. Comorbid conditions that must be addressed fall roughly into four categories as follows:

Significant Relationship Conflict

Many cases we deal with are presented as sexual problems but are clearly by-products of acrimonious relationships. For example, a man may be presenting with ED or a woman may be presenting with low desire but the real problem is severe couple conflict. The couple may, in fact, be coming to therapy as a last resort so they can at least state that they have tried everything. The assessment interview can usually identify the sources of a couple's conflict such as verbal abuse, faulty communication, discovery of a sexual affair, or years of anger due to unfulfilled expectations. What needs to be determined is whether or not the couple's relationship problem is treatable and whether or not treatment changes will make a difference in a couple's feelings toward each other.

Some relationship problems are untreatable because the identified conflict might be based on an unchangeable factor such as a partner's core values or cultural identity. One of us (J. P. W.) recently was assessing the

female partner of a man who complained of ED. She stated that she had never found her husband sexually attractive and that she also had severe conflicts with the values of her husband's culture, which he embraced. She stated that objectively she knew that her husband was a good-looking man but she personally never found him attractive. She also recognized the cultural differences before marriage but thought her perceptions would change in time. (They did not.) The couple had been married for almost 30 years and stayed together initially because of their two children and more recently because of financial need. At this point, she had no expectation that her perceptions could ever change.

In other cases, there are couples who present with problems that are changeable, such as faulty communication patterns or inattentiveness to a partner, but the problems may have existed for years or may have been so deeply distressing that damaged feelings won't change even if behavior does. A therapist should inquire as to whether or not there is "too much water over the dam" before launching into treatment.

Treatment of couple's conflict before addressing sexual issues is most productive when the problems are treatable and the changes will result in more positive feelings. The length of such therapy may be only a few sessions or may be very protracted. In a couple that one of us (J. P. W.) treated, therapy involved a year of communication training and resolving conflicts related to pornography use before sexual problems could be directly addressed.

Significant Stressors in an Individual's/Couple's Life

Many individuals and couples whom we see present with significant life stressors such as financial problems, legal problems, or problems related to the health and well-being of family members. Such problems generally preoccupy a person's thoughts and make it difficult for most people to feel in the mood for sex. In addition to encountering people in financial crisis or out of work, we also encounter many individuals taking daily care of an impaired or chronically ill family member. Until there is relief from such problems and responsibilities or until effective strategies for coping are developed, such stressors may continue to interfere with opportunities for sexual involvement and sexual interest. The strategies for helping an individual or couple through a stressful situation are, of course, dependent on the nature of the stressor. In some cases, it is best to postpone therapy until the crisis has been resolved or has passed; in other cases, it might be helpful for the therapist to work with the individual or couple with specific coping strategies to minimize the stress. In either scenario, the shift back to a focus on sexual concerns would occur when the stress has been reduced to a manageable level.

Significant Mental and/or Physical Health Concerns

If a patient presents with an unresolved or unstable mental health problem, it can be futile and a waste of time to address sexual concerns. Any major mental health disorder that is untreated, unresolved, or unstable can potentially interfere with a focus on sex. The types of disorders we most commonly see that fall into this category are depression, bipolar disorder, obsessive–compulsive disorder, general anxiety disorder, posttraumatic stress disorder, and psychotic disorders. We have also had a number of cases of severe attention/deficit-hyperactivity disorder that benefit from treatment before addressing the sexual disorder. It appears that any disorder that disrupts a person's ability to focus on sexual stimulation or occupies a person's thoughts with nonsexual content will disrupt sexual behavior and is best attended to before treating the sexual concerns.

Significant Substance Abuse Problems

For some individuals, a moderate use of alcohol or certain drugs may be beneficial to, or at least not interfere with, sexual behavior. However, very heavy use and addiction most often interfere with sex on a physiological as well as a cognitive level. In many cases, the substance use is very obviously interfering with many aspects of a person's life including sex and there is little benefit that can be derived from focusing on sex. Such cases should be referred to a substance abuse expert and the individual or couple should be told that the sexual problem cannot be treated until the substance use is under control. In other cases, however, the exact impact of the substance use may not be obvious. Individuals in this second category can be challenged to suspend their use of the substance and see what impact this might have on relationship issues and sexual behavior/performance. If individuals are not able to suspend their use of a substance, then they should also be referred to a substance abuse expert.

OVERVIEW OF THERAPY

After addressing any potential interfering comorbid problems, therapy can then focus directly on resolving sexual concerns. In spite of today's increased patient knowledge and sophistication regarding therapy, we still advise therapists to explain the content and process of therapy to each new patient. Patients appear to be put at ease and greatly appreciate an organized statement regarding what therapy will include and how a programmatic approach will be followed.

The outline presented in Chapter 12 for conducting a comprehensive

assessment interview applies to therapy as well. Thus, we recommend that you make assumptions, set goals, attend to process issues, and follow a planned structure. We develop each of these recommendations below.

Assumptions

As in the case of assessment, it is helpful to begin therapy with a set of assumptions. These assumptions are educated guesses (i.e., hypotheses) that you make in order to facilitate efficient and effective progress. Some helpful assumptions that may prepare you for common problems are as follows:

- The patient has a narrow definition of sex (e.g., "sex = intercourse"); he or she will focus on performance as a marker of success.
- The patient has stereotyped views of masculine and feminine sex roles; these views will interfere with the assimilation of new information.
- The patient does not understand the ingredients conducive to sexual arousal (e.g., favorable times to have sex, interfering factors).
- The patient has a pattern of avoidance of sexual interactions; as a result, he or she may unintentionally sabotage therapy.

By making these assumptions in advance, you will be prepared for potential pitfalls in the therapeutic process and increase the likelihood of success. We appreciate that some readers may find setting assumptions inappropriate, perhaps because this might suggest that we do not listen to what our patients bring to therapy. This is an important point to address. We believe that one can go too far in setting assumptions and encourage caution here. However, we also believe that most clinicians tend to have assumptions, and we simply urge you to make these more explicit and consistent with clinical experience. Of course, if the assumptions prove to be inaccurate, you must adjust your approach. We set up our assumptions such that, in most cases, an inaccurate assumption indicates a therapeutic gain.

Goals

In our view, the primary goal of therapy should be to create or restore mutual sexual comfort and satisfaction. More specific goals should be established only after the completion of a comprehensive assessment. We have found that patients often enter therapy with very specific goals, but that after the assessment new goals need to be established. For example, a couple with severe communication problems may enter therapy with the goal of having the female partner experience coital orgasm. This goal,

established by the couple, is not likely to be reached as long as angry conflict exists between the partners. It is your task as the therapist to help the couple to understand the psychological as well as the mechanical factors that contribute to satisfactory arousal and sexual enjoyment; in so doing, new goals are established.

New goals must be presented to the couple in such a way that the partners understand that in order to reach their ultimate goals, they must first work on preliminary goals. Moreover, it is important for the couple to understand that achieving these preliminary goals may cause discomfort. We encourage patients to conceptualize these preliminary goals as "stepping stones" or "building a foundation." Finally, and very importantly, goals should be discussed openly with the couple.

As a therapist, you need to be careful not to establish goals that increase performance anxiety. For example, goals such as "increasing erection firmness," "producing orgasm," or "controlling ejaculation" may actually exacerbate the problem, especially if performance anxiety is inhibiting the response. If such performance-related outcomes do occur, they should be looked upon as pleasant side effects, secondary to achievement of the goal of increasing mutual pleasure.

Process

Many important interpersonal and interactive nuances can occur during therapy. Although these are not part of the planned therapy program, they can be crucial to therapy success. Factors such as your appearance, the appearance of your office, and your educational credentials may be important to a patient. Being responsive to patient requests for information and returning phone calls promptly also facilitate a positive rapport. These factors are present in any therapeutic interaction and are not the special domain of sex therapy.

Sex therapy brings with it its own set of important process issues. The discussion of private and potentially embarrassing material requires special sensitivity. It is common for a patient to say, "I have never told this to anyone else before." Your reaction to such information is crucial and can either encourage or discourage further discussion. As noted in Chapter 12, we have had patients say, "I tried to tell this to my doctor, but he appeared so uncomfortable that I couldn't discuss it." You can encourage further discussion by acknowledging that the patient may find it difficult to discuss sexual topics, by reassuring the patient of your experience in dealing with sexual problems, and by remaining poised and calm, even if your patient(s) reveal information or sexual behavior that strikes you as bizarre (this does happen!).

Careful attention should also be paid to the development of therapist–patient feelings (i.e., transference and countertransference). Keep in mind

that intimate discussion about sexual issues with a caring therapist may set the stage for sexual fantasies and attractions. As a therapist, you must be aware of the potentially seductive nature of the therapy process (especially with a single patient) and avoid the personalization of the therapist–patient relationship. If you suspect that the patient is behaving in a seductive manner, then the therapy should address this issue. If you feel attracted to your patient or find yourself behaving in a seductive manner, you should consult with a colleague immediately. Ask him or her to help you to assess the magnitude of the problem and to devise a strategy for working through this "countertransference." The colleague may encourage you to discuss the problem with your patient or to refer the patient to another therapist. We wish to make it clear that, from our perspective (and that of many professional organizations, we might add), sexual intimacy between a patient and therapist is unacceptable and cannot be justified under any circumstances.

When working with heterosexual couples, you must avoid the appearance of taking sides. A couple will often make the assumption that a therapist is aligned with the same-gender patient. This issue should be discussed at the beginning of therapy, and throughout therapy as needed, to counteract such assumptions. We attempt to identify and repeat during almost every session the issues that each partner has to work on independently (e.g., making more positive statements to his or her partner) as well as the issues that the couple has to work on together (e.g., setting aside time for communication or sensate focus). With this strategy, each partner should not feel that only he or she is the focus of change.

Structure and Content

The next consideration in sex therapy is the structure and content of therapy itself. As noted in Chapter 12, therapy begins during the assessment, when key target problems are identified. So, for example, if relationship issues are of sufficient magnitude to interfere with progress, these must be treated first. If relationship issues are not destructive or interfering, then sex therapy can begin. From our perspective, therapy can be construed as having three stages:

Stage I

The first stage of sex therapy usually focuses on some or all of the following goals: acquiring knowledge, negotiating sexual differences, identifying desired sexual behaviors (and approaches to sex), and acknowledging performance anxiety. Depending on the extent of a couple's or individual's problems, this first stage of therapy may include anywhere from one to several session(s). Basically, Stage I therapy is focused on ensuring that

proper knowledge, goals, and motivation exist to proceed with a focused, sex therapy approach.

Stage II

The second stage of therapy involves the active work on more specific sexual goals identified during Stage I. This may include, for example, practicing new approaches and behaviors to reduce performance anxiety, using fantasy training to increase arousal, and practicing communication to reduce misunderstanding and express sexual desires. Cognitive approaches to improve maladaptive beliefs also occur during this stage.

Stage III

The third stage of therapy involves reviewing treatment process and outcomes (to consolidate gains and achieve a sense of accomplishment), and planning for treatment generalization and relapse prevention. Stage III should begin when Stage II programs appear to be successful and moving along with only minimal therapist guidance. We begin this stage with a review of how the sexual problem developed, what the couple or individual was experiencing at the beginning of therapy, what goals were established, and what goals were achieved. Next, we discuss anticipated pitfalls in the future (that might lead to a recurrence of problems) and a review of the strategy to deal with such problems.

Spacing of Sessions and Length of Therapy

Our general approach to most sexual dysfunction problems is to space sessions at weekly intervals. When possible, we will see patients at a more accelerated pace during the initial assessment. During therapy, however, our experience suggests that weekly sessions allow time for homework practice and reflection without losing continuity. The spacing of sessions should be reevaluated regularly to determine whether a different schedule will better serve the couple, for whatever reason, without disrupting the flow of therapy. If a couple or individual is very compliant in following therapy instructions, then spacing sessions every 2, 3, or even 4 weeks is possible once progress has been established. When sessions are spaced apart by more than a few weeks, instructions can be given that will allow for phone contact and even emergency sessions if needed. Most of our patients have been able to reach therapy goals successfully within 15 sessions.

This outline contains the elements of a comprehensive approach to therapy, but it is only a heuristic guide. It is always necessary to customize the treatment plan you develop to the needs of a patient or couple.

COMMON INGREDIENTS FOR THE PSYCHOSOCIAL TREATMENT OF SEXUAL DYSFUNCTION

A number of *common ingredients* and/or strategies are helpful in addressing almost all sexual dysfunction problems in men and women. In addition to discussing these ingredients that are present when treating most sexual problems, we follow with a discussion of additional *strategies for specific disorders*. Starting with the common ingredients, however, the most important treatment ingredient that is inherent in all therapy situations is *psychoeducation*. Psychoeducation encompasses a number of subcategories.

Putting Problems into Perspective

There is no question that a sexual problem can be very stressful, can undermine self-esteem and self-confidence, and can lead to depression, breakups in relationships and even suicide. It is, therefore, often very helpful to put an individual's or couple's sexual problem into perspective. Many individuals and couples view a sexual problem as an unchangeable trait that defines who they are and ignores the total picture. This view is especially problematic in those individuals who have a cognitive style expressed in black-and-white terms. In most cases, it is very helpful to point out the strengths that an individual or couples also possess beyond sex and it is also helpful to define sexuality in terms of *intimacy* rather than performance. Sex is focused on physical and emotional pleasure while intimacy includes orgasmic sex but also love, joking, flirting, touching, affection, sharing secrets and vulnerabilities, and open communication. An excellent discussion of intimacy that is very useful for patients can be found in a book by Alterowitz and Alterowitz (2004). Although this book is oriented toward prostate cancer survivors, the focus on intimacy is valuable and appropriate for all men experiencing ED and their partners.

It is also extremely important to help all patients to view sex as being on a continuum composed of many different behaviors and that any person engaged in sex has choices and can pick and choose what to include. Furthermore, the choice of sexual ingredients can change in each sexual encounter. In summary, the above perspective gives a person and a couple the message that there is more than sex that defines a person's worth. It also conveys the message that a person can give pleasure and develop intimacy in many different ways and everything doesn't have to be based on a narrow view of sex as they may have defined it.

Normalizing

In spite of the inundation of advertisements in the media focused on treating sexual dysfunction in men and women, we still frequently hear from

our patients that they thought their sexual problem was unique. Some men and women have confessed that they were afraid to even tell their doctor about their problem because they thought they would either be laughed at or thought to be weird. As a therapist, you can play a very important role by identifying for your patients that you have treated similar problems and that many individuals share similar concerns. When possible and appropriate, it is often helpful to site data on such topics as the commonness of masturbation in men and women, the frequency of sex for couples, and the duration of sex. Accurate data encourages discussion and alleviates anxiety.

Eliminating Blame

Many individuals and couples enter therapy either blaming themselves or their partner for sexual problems. Assigning blame, however, does not solve problems and detracts from the importance of a couple's interaction that is needed to produce a rewarding and satisfying sexual experience. Blame is also often predicated on the false assumption that "correct" sex has to occur in a very specific way and on every occasion. Therapists who deal with sexual problems are in a very privileged position that has borne witness to the diversity of sexual behavior. While one patient is 100% sure that sex should be gentle and slow, another patient is 100% sure that sex should be forceful and unhesitating. There are, of course, no right or wrong approaches but there are individual preferences. By eliminating blame, an individual is in a better position to ask more important questions: What are the conditions and stimulation that help my partner to feel sexual? And, what can I do during sex that pleases my partner? By focusing on these questions, a couple will improve their communication about sexual matters and operate on facts rather than potentially false assumptions. No one knows a priori what a potential sex partner will find most pleasing. Sexual experience with that partner and open communication will find the true answer.

Correcting Misunderstandings

The widespread availability of information about sex on the Internet has served to educate people about sex but has also confused and befuddled people as they attempt to wade through the quagmire and seemingly endless array of "facts." It is not surprising that many of our patients enter therapy harboring myths and misunderstandings about sexuality. One very common myth about male sexuality that seems to be held by many men and women is that "men should always be interested in sex." Endorsing this myth leads to performance anxiety in men as they try to function sexually

under unfavorable conditions and leads to feelings of rejection on the part of women as they wonder why their male partner is not responding to their sexual overtures.

Men and women also seem to commonly have many misunderstandings about the impact of aging on sexual desire and sexual performance. Most notable is the misbelief that sex stops at a certain age. Such a belief obscures a search for the real biomedical and psychosocial contributions to a sexual decline. There are also many false beliefs related to masturbation that we commonly encounter. Many men and women, for example, view masturbation as a sign of mental disturbance or sexual inadequacy, especially if a person has an available sexual partner.

Although there are certainly numerous other sexual myths and misunderstandings that cloud clear thinking and viable solutions to sexual problems, it is important to reiterate that sexual myths and misunderstandings are widespread and alive and well in both well-educated and uneducated populations. Today's therapist, dealing with sexual problems, must assume the possibilities of misunderstandings in all of their patients.

Identifying All Contributions to Sexual Problems

In most cases, patients enter therapy with very little understanding of the factors that are contributing to their sexual problem(s) and they are looking for a single explanation of the cause. Furthermore, the cause that is most often hoped for by patients is a medical cause. People seem to be more anxious when faced by the thought that the cause is "psychologically" based, and therefore their fault. The "wish" for a medical cause is based on the misunderstanding that the solution will be a simple pill. We provide patients with the conceptual framework that sexual problems are most often a result of a convergence of many factors and that therapy will provide them with an understanding of the factors contributing to their problem and ways to address their problem. We also provide reassurance that "psychological" factors do not equal fault nor do they indicate mental problems.

Changing the Sexual Environment

All sexual problems can be adversely affected by an environment that is not conducive to a comfortable and private experience. Consequently, it is important for the therapist to explore with each person and couple the conditions under which sex usually occurs. Is the sexual environment free from distractions such as those associated with excessive noise, bright lights, and household pets? We routinely ask about pets since there have been many cases we have dealt with in which the intrusion of animals is one of

the main contributing factors that interferes with sex. Barking and licking dogs, snuggling cats, and staring birds have all been mentioned as interfering with sex. It is actually amazing how many people routinely have pets in bed with them and how ill-equiped and helpless people are to establish boundaries for their pets.

We also run into many cases in which young children, teenagers, and other relatives in a household present intrusions into a couple's sense of privacy. Whether it is unexpected bursts through the bedroom door or the worry that someone else in the household will hear the sounds of sex, the presence of others in a household can be a sexually inhibiting factor.

It is also important to explore a person's schedule of activities, responsibilities, and work hours to obtain a sense of what relaxed free time exists in a person's life. Does sex occur to take advantage of a free moment, or is it planned and relaxed? People who travel, have long-distance relationships, or have opposite work shifts from their partner often find themselves taking advantage of a moment for sex even if they do not feel like it. The thinking seems to be "We better have sex now while we have the opportunity or else it will be a long time before we have another opportunity." Such a pressured approach to sex often creates or exacerbates sexual problems.

Improving Communication

Communication problems are encountered frequently when dealing with sexual dysfunction. We have developed a handout for patients that serves as both an assessment tool and a therapeutic guide. The handout is 10 pages long and describes common couples' communication problems and provides suggestions about how to overcome these problems. The typical problems in communication include the following:

- *Off beam.* Partners start to discuss one problem and drift into another.
- *Mind reading.* Partners guess the meaning of each other's statements because they think they know each other so well.
- *"Kitchen sink."* Partners start discussing one problem and bring in every other problem.
- *"Yes, but."* Each partner listens but continues to think that the other is wrong.
- *Cross-complaining.* Each response contains a new complaint.
- *Standoff.* Partners tend to repeat the same argument over and over, without progress or resolution.

For those patients who are identified as needing help with communication, we typically instruct them to read the handout independently (we

give one to each partner) and ask them to check off the patterns that might apply to their relationship. We then discuss the various areas of communication difficulties, often with examples from the couple's own experiences. It is very important for you to establish from the beginning that the review of the examples is designed to look at the process of communication and not to illustrate or determine who was right or wrong. Therapists may benefit by referring to the work of Gottman, whose guide to communication training for couple's is a classic in the field (Gottman, Notarius, Gonso, & Markman, 1976). Effective communication is facilitated by encouraging basic skills of listening, compromising, and using polite tones. We also encourage couples to set aside time each day to share events of the day, problem-solve, and establish plans and schedules.

As the therapist, you should serve as a model of good communication during all sessions. This is achieved by listening actively, by displaying empathy, by asking patients to express themselves clearly, and by other such social and communication skills. In addition, you should continually look for improvement in communication skills and point these out to a couple when they occur. It is helpful for you to inform the couple that, throughout the therapy, communication skills will be monitored continually and addressed when appropriate. If this is stated at the outset, an individual will not feel picked on when a communication issue is raised. In some cases, sexual dysfunction problems cannot be addressed until communication improves. In such cases, we often point out that sexual expression is a specific form of communication.

Sensate Focus

Just as the interview serves as the cornerstone of sex assessment, sensate focus serves as the cornerstone for sex therapy. This approach can be used to address any sexual problem in which there is an excessive focus on performance and outcome rather than an enjoyment of the process within the moment of sex. The sensate-focus approach and procedures were initially developed by Masters and Johnson (1970), and can be used to address a number of aspects of improving an individual's or couple's sexual behavior. More than 40 years later, we still find ourselves introducing this approach into a majority of cases we treat. Couples and individuals readily understand and appreciate this approach when it is explained adequately and tailored to their needs. We still find that many patients have attempted variations of sensate focus on their own or at the suggestion of their medical doctor or friends, but without success. The usual difficulty is that couples experience performance pressure, even if they agree not to perform! Under the guidance of a therapist, a strict adherence to the principles and purpose of sensate focus can more likely be followed. The therapist helps to keep couples on track and adjust procedures as needed.

Principles

The first and most important principle of sensate focus involves helping the patient or couple to develop a heightened awareness of, and to focus on, sensations rather than performance—thus, "sensate focus." By doing this, a person or couple reduces anxiety by striving toward something that is immediately achievable (i.e., to enjoy touching), rather than striving toward a goal (e.g., erection, orgasm, controlled ejaculation) that may not be achievable; the latter increases the risk of "failure" and embarrassment. For some patients, we find it helpful to frame this principle as "focusing on the moment," or "being in the here and now," or "enjoying the trip rather than focusing on the destination," or related metaphors. We have recently found that an increasing number of patients have heard of, or have some experience with mindfulness meditation, and for these individuals sensate focus can be framed within the same concept. Over all, most of our patients get the concept.

Second, sensate focus involves a structured but flexible approach to therapy. It is structured in that patients are given explicit instructions for intimacy; if these instructions are followed, the patients/partners will gradually regain confidence in themselves and in their relationship. Although it is structured in the sense that couples know what is expected of them, sensate focus is very flexible in that it can be accommodated to any couple's unique circumstances. It is critical that, as a therapist, you accommodate the procedures (described later) to the specific needs of your patients.

Third, sensate focus is a gradual approach to change. It is anticipated that change will take time, and there is no effort to rush ahead. Theoretically, the procedure of breaking down a complex behavior into smaller steps may be seen as a form of operant shaping, because an individual will gain a sense of accomplishment or self-efficacy through modest but attainable "successes" (Bandura, 1997); this may also be conceptualized as an *in vivo* desensitization procedure when anxiety reduction is the goal.

One example of this gradual success principle is that patients discontinue intercourse in the early stages of therapy, so that they can relearn the "basics" of being affectionate, receiving pleasure, and so on. These "basics" are important elements for increasing sexual interest and arousal but are often diminished in couples in a long-term relationship. For some patients, intercourse will not be reintroduced into their sexual repertoire for weeks or even months! The gradual approach can be off-putting to some because it can seem slow, especially in a culture that emphasizes speed—on the Internet, in the microwave kitchen, and with "instant everything." Thus, special care is needed in explaining the importance of this gradual approach to patients.

Fourth, sensate-focus therapy and home exercises need to be con-

ducted in a shared and nonthreatening environment. As therapist, you need to attend to both partners in a couple to be sure that the exercises are proceeding at a nonthreatening pace.

You should be mindful of the principles behind sensate focus as you proceed. The procedures outlined below, and in other sources, are not intended to be followed in a cookbook-type fashion. Rather, they are offered as a heuristic guide and should only be followed as long as they are consistent with the spirit of the principles just outlined.

Procedures

The actual procedures of sensate focus involve encouraging partners to approach intimate physical and emotional involvement with each other in a gradual, nonthreatening manner. The general operating procedure involves homework, which encourages the couple to engage in sexually related exercises, and ongoing therapy sessions, which are used to discuss the exercises, emotions triggered by these exercises, problems, and so forth.

Homework involves the provision of explicit instructions to the patients; these instructions require practice of some exercises outside of the therapeutic sessions. It is made clear to the patients that the homework will be reviewed and modified (as necessary) at each session. The homework exercises can be broken down into four "steps," which are typically followed in a sequential fashion, but there are no absolutes here. The decision as to whether each step should be included, and how much time should be devoted to each, requires your clinical judgment.

The first step of sensate focus typically includes "nongenital pleasuring" (i.e., touching) while both partners are dressed in comfortable clothing. The least threatening behaviors may include back rubs or holding hands. Variations in the amount of clothing worn, the length of sessions, who initiates, the types of behaviors participated in, and the frequency of sessions should all be discussed in the therapy sessions before a couple goes home to practice. The partners should begin their physical involvement at a level that is acceptable to both.

Because many couples will find this to be a somewhat slow and indirect method (to say the least), you must emphasize right from the start that (1) they are going through a necessary process in order to address their long-term goal, but that (2) the short-term goal is to focus on sensations and not performance. Discuss with each couple the mechanics of the approach, including structured versus unstructured approach, frequency, potentially interfering factors, and anticipation of any problems.

Even if you give what you believe to be a clear explanation of the nonperformance aspects of sensate focus, some patients will miss the point! So we try to be particularly explicit and remind patients: "The next time you

have a therapy session, I will not ask you about erections or orgasms; what I will ask you about is your ability to concentrate on receiving and giving pleasure, and your ability to enjoy what you are doing." We repeat this message because most couples are performance-oriented (i.e., they focus on erection and orgasm); unless they are disabused of this notion, they will retain performance criteria during the sensate-focus exercises. At this point, you might remind the patient or couple about the concept of performance anxiety. This should include exposing "all-or-none" thinking (e.g., "sex = intercourse") and other factors that interfere with enjoyable sex. The application of sensate focus cannot proceed unless the partners understand this concept, acknowledge that it applies to them, and appreciate the need for a different approach in thinking and behavior.

The second step, typically, will involve "genital pleasuring." During this phase of therapy, partners are encouraged to extend gentle touching to the genitals and breasts. Partners are encouraged to caress each other, in turn, in a way that is pleasurable. As before, the couple should be discouraged from focusing on performance-related goals (i.e., erection, orgasm). As the therapy progresses through sensate focus, you should review factors that facilitate or inhibit goals. Discussing these factors with the partners in a nonjudgmental way can help them feel more in control of their own progress and less like pupils in a classroom.

Once a couple becomes comfortable with genital touching and is ready to resume sexual intercourse, we find it necessary to emphasize that even sexual intercourse can be broken down into several behaviors. Thus, we might encourage some couples to engage in "containment without thrusting"; that is, the receptive partner (i.e., the woman in heterosexual couples) permits penetration and controls all aspects of this exercise. For example, the depth of penetration and the amount of time spent on penetration can be varied. Again, we encourage flexibility and variation in order to remove pressure associated with a couple's tendency to think in "all-or-none" terms.

A common problem with this stage of sensate focus is that some therapists rigidly adhere to the proscription on intercourse (Lipsius, 1987). If employed mechanically, proscription of intercourse can lead to loss of erotic feelings, loss of spontaneity, unnecessary frustration, and increased resistance. Our approach to the proscription issue is to discuss with the couple all of the potential benefits and liabilities of proscription, and to point out that the couple is working on a process that will build for the future. Pressure to ensure that a couple adheres to a proscription is dependent to a large degree on clinical judgment.

In our view, a proscriptive approach may be warranted under certain circumstances, for example: (1) if a couple is very stressed by "sexual performance," (2) when there are a lot of interfering performance-oriented thoughts, or (3) if the couple has avoided all physical contact. On the other

hand, couples who have not approached sexual relations so rigidly or with such intense emotional reactions may benefit from a general understanding of the purpose of sensate focus, but with a more relaxed attitude toward proscription.

The final step of sensate focus proper includes thrusting and intercourse. Again, it is usually a good idea to encourage the receptive partner to initiate the movement, and for movements to be slow and gradual. As always, the couple is encouraged to focus on the sensations associated with intercourse, and not to be concerned about orgasm. Urge partners to experiment with different positions and discourage them from relying on the same position(s) they have used prior to therapy. Intercourse should conceptually always be thought of as an option and not the goal.

Pitfalls

Unfortunately, sensate focus is often misunderstood and misapplied. It is not unusual for couples to enter therapy and report that they had tried to "abstain from sex" or "just fondle" and this did not work. Recently, a couple enrolled in therapy for the purpose of dealing with erectile difficulties. In response to a question about past therapy, the man explained that they had previously participated in sex therapy and had tried sensate focus. The approach used was "not to have sex for a 2-week period." The couple had no understanding of the purpose of the procedure or the guidelines for their behavior. They left their previous therapy very dissatisfied.

We often encounter variations of the misapplication of sensate focus. It is a very simplistic procedure on the surface and a very effective strategy, but it is easily misapplied and misunderstood by both therapist and patient. The most common mistake that therapists make is not explaining the details of the procedure and not engaging the couple in the decision-making process of the application. This often results in noncompliance. A second common mistake is demanding performance as part of the procedure (e.g., "The next step in the procedure is to stimulate your partner in the genital area to the point of orgasm"). This type of statement may increase performance anxiety, especially in a vulnerable person. It would be preferable to state, "You have done well so far in concentrating on your sensations and feelings as you and your partner stimulate each other. Thus far you have included genital caressing. What do you feel the next step should be?" This approach allows a variety of responses without an anticipation of sexual failure or pressure. One additional mistake some therapists make involves premature termination of the sensate-focus approach when a couple is noncompliant or encounters difficulties. Premature termination only serves to reinforce avoidance. Difficulties should be discussed at length, and barriers to progress should be identified and removed. Generally, we allow 3 weeks of noncompliance before changing procedures.

Another opportunity for disaster presents itself when therapy moves into the area of "homework procedures." At this time, there exists a potential conflict between being natural and unstructured, and being mechanical and structured. Most couples and individuals express a preference to approach homework assignments in a "natural, unstructured" manner. With this approach, you describe the procedures involved and the principles behind the procedures, but leave it up to the couple to schedule other details, such as the frequency and times for "practice." Although you may feel intuitively that this is the preferred strategy, you can expect couples to return to therapy without having carried out the assignment! The reason for this is that, all too often, there is a long history of sexual avoidance; thus, the individual or couple cannot get started without raising anxiety levels unacceptably high. Thus, we usually explain the pros and cons of structured versus unstructured strategies before providing homework exercises. The couple can then choose a strategy and, in so doing, can be fully aware of the potential for noncompliance. At times, a patient may "try out" a certain strategy and, upon failure, may adopt a different approach. In addition to exploring the issue of structured versus unstructured practice, you should explore other potential obstacles to carrying out therapy procedures—for example, children or other family living in the house, work schedules, medical concerns, and travel plans. Once these potential obstacles are identified, and solutions generated, then the rationale and details of homework can begin.

Benefits

There are many benefits that may result from the sensate-focus approach. New behaviors may be learned, along with new approaches to sexual interactions. We have dealt with couples who have had very narrow approaches to sex. It is not unusual, for example, for a couple to report that they engage in no touching behavior at all. They may kiss once, and then have intercourse! We have even encountered couples who view foreplay as "something that kids do." For such a couple, sensate focus offers a structured opportunity to challenge established habits that may be restricting pleasure and causing sex problems.

Sensate focus may also help to change patients' perception of their partners. A common problem we run into is that many men approach sexual intimacy with intercourse and orgasm as the only goals. In a heterosexual couple, the female partner may begin to see herself as an object of her partner's pleasure and not as a companion who is loved. The sensate-focus procedure can help partners to focus on each other with mutual affection rather than as sexual toys or objects of arousal.

Sensate focus also offers an opportunity for individuals to learn to communicate with their partners about sexual pleasures and preferences.

It is not at all unusual to encounter couples who have been married for many years and have no idea what their partner likes or dislikes about sex. Sensate focus can also be quite diagnostic. Difficulties that emerge during sensate focus often carry important information about a couple's other problems. These other problems often cannot be addressed through sensate focus itself, but the exercises can elicit such concerns that might otherwise go unnoticed.

Concluding Comments

Sensate focus should be viewed as one part of a total treatment approach; *it is not a complete therapy in itself.* Thus, communication issues, faulty attitudes that interfere with sexual enjoyment, and nonsexual marital conflicts are examples of therapy concerns that may be dealt with concomitantly with sensate focus. Sensate focus is a procedure that has multiple benefits and can be used as part of a treatment program for every category of sexual dysfunction problems.

SPECIALIZED PROCEDURES FOR SPECIFIC DISORDERS

Psychosocial treatment for any specific disorder may include any one or all of the above common therapy strategies in addition to the biomedical strategies. In this section, we provide additional psychosocial treatment strategies and information that may be considered for specific disorders (see also Tables 14.1–14.4, at the end of the chapter).

Erectile Disorder

The most common strategy that is used in almost all cases of ED is sensate focus as explained above. The reason that sensate focus is most commonly used is because "*performance anxiety*" plays a significant role in most cases of ED. In implementing sensate focus, it is very important that the male presenting with ED and his partner are fully understanding of this concept. In heterosexual couples, it is useful to explain to the female partner that men are more vulnerable to performance anxiety because a man's penis is visible, and therefore both he and his partner are aware of the degree of erection. The *visibility and awareness* create *vigilance and focus* on the penis that results in feelings of pressure to perform. To help patients fully understand this concept, we use analogies of sleep, athletic performance, and musical performance. In all of these activities, the more a person worries about the outcome, the more likely the outcome (e.g., poor sleep, striking out in baseball or missing the putt in golf, hitting the wrong key in a piano concert) is a failure. In men who are single, or who

have an uncooperative or uninvolved partner, it is important that the man presenting with ED fully understands the concept of performance anxiety and is able to explain it to a partner when necessary. We also advise single men to select a partner who is self-assured and is "easy going," flexible, and accepting (i.e., not critical).

In some cases of ED, a significant contributing factor is the lack of sufficient erotic stimulation. The lack of erotic stimulation may be due to interfering environmental factors but may also be due to a lack of variety and skill on the part of the male and/or his partner. Neither love nor a sense of duty/obligation alone will typically be sufficient to inspire an erection in most males. Men require an input of erotic stimulation to produce an erection. The erotic stimulation can come from internal fantasies or the actions and appearance of a partner. Men compared to women are especially reactive to erotic visual stimulation. This point can be understood by looking at the differences between how men and women use erotic stimulation on the Internet. It is very typical for men to look at erotic visual images and masturbate while females are more prone to reading erotic stories or engaging in erotic chats and cybersex. Women are less likely to masturbate while viewing erotic images (Hald, 2006; Weiser, 2000). Couples who have been together for a long period of time and who have a routine and unvaried approach to sex are vulnerable to ED as well as to a decrease in sexual desire. A man who boasts that his partner is always available for sex and never turns him down is actually describing a condition that is conducive to creating sexual problems. Sexual arousal and interest benefit from novelty, risk, and unpredictability.

These elements are, of course, always present with a new partner or in an affair and mislead some into thinking that the difference in the intensity of a sexual response is a lacking in their usual partner rather than due to the change in circumstances. In couples who lack important elements of erotic arousal, it is helpful to explore and suggest ways to introduce erotic stimulation. Our approach is to discuss the importance of these elements and then work with an individual or couple to identify what might be doable and acceptable. A therapist should be cautious about suggesting strategies that may be objectionable for one reason or another. We have found it helpful for couples to view and discuss an illustrated book designed to help couples introduce sexual novelty such as *Sexopedia* by Anne Hooper (2002). This book may be useful for promoting sexual communication as well as generating new ideas.

Throughout treatment for ED, you should monitor and attend to interfering thoughts, feelings of comfort, and good partner relationship. You should also help your patient to avoid performance-oriented approaches to sex by accepting a broad definition of sex; that is, the goal is to remind the patient to view sex as more than just intercourse—instead, sex involves a wide range of behaviors. We find the use of a menu analogy to be very helpful as a way to reduce performance pressure and to broaden the definition

of sex. With this analogy, patients are told to conceptualize sex as a meal, and to pick and choose from the menu, depending upon their appetite and taste. Appetite and taste for sex may be expected to vary from occasion to occasion and person to person. Discussing this analogy helps to reduce performance anxiety.

Even in cases where there is clearly a biomedical basis for the erectile problem, psychosocial issues should be considered in treatment. Negative, interfering thoughts (especially in long-standing problems) may be present in many cases of erectile disorder. When a man's partner is involved in treatment, it is also important to consider his or her cognitions concerning the dysfunction. A man with erectile difficulty may harbor negative associations around his problem, and it is also likely that his partner may have negative cognitions. Typical partner responses in homosexual as well as heterosexual couples may include the following:

"I'm no longer attractive."
"He doesn't love me anymore."
"He must be having an affair with someone else."
"He isn't trying; he doesn't want to have sex with me."

We always ask the partner what he or she thinks is the cause of the erectile problem. It is important to help clear up possible misunderstandings before proceeding with any intervention; since, if potential misunderstandings are not addressed, it is likely that they will arise again and sabotage treatment progress.

Female Orgasmic Disorder

FOD is often experienced psychologically in a similar fashion to a man's experience of ED. In both conditions, performance anxiety can play a prominent role and maintain the problem regardless of the original cause. As in ED, worry about the outcome interferes with the sexual process and healthy functioning. And the harder one tries to achieve a sexual goal, whether it is erection or orgasm, the more unlikely that the goal will be achieved.

FOD, a very frustrating dysfunction, can lead to a total avoidance of sexual relations. Because of the strong association with performance anxiety, sensate focus is often advised. Sensate focus often will help to combat distracting and interfering thoughts. Directed masturbation (DM) with appropriate use of pleasurable erotic thoughts is also often helpful, especially in cases of primary anorgasmia. The effectiveness of DM benefits from accurate information about orgasm and includes self-exploration and self-pleasuring. As in the case of other dysfunctions, it is necessary to conduct a detailed assessment to determine whether the problem has always

existed (i.e., lifelong or acquired) or is associated with a current problem or condition (i.e., generalized or situational).

The book *Becoming Orgasmic* (Heiman & LoPiccolo, 1988) outlines in detail a program for helping women to learn to masturbate and to become orgasmic. This is a revised edition of a widely acclaimed earlier volume and is still relevant today; it provides excellent information and its approach to the problem is considered very helpful. Research indicates that DM approaches are successful in cases with primary FOD (Graham, 2014; Heiman, 2002; TerKuile, Both, & van Lankveld, 2012).

We have also found in many instances that FOD is associated with negative feelings toward sex (in general), oneself, or one's partner. With some women, we have also encountered fears regarding fainting, losing control, or increased vulnerability associated with the concept of orgasm. Rarely, in our experience, is the difficulty just a problem of poor sexual technique. In order to use a procedure such as DM, you should first explore in detail whether negative cognitions and attitudes are present. It would be a strategic blunder to suggest DM without first assessing the woman's and her partner's beliefs about the nature of the problem and the acceptability of masturbation. Once these feelings have been explored and both partners are comfortable, the physiology of orgasm should be explained and DM initiated.

It is also important to explore a woman's expectations about orgasm to ensure that they are realistic. Explaining that orgasm occurs on a continuum from mild to intense is often helpful. It is also helpful to normalize the occurrence of orgasm by any means including oral sex, manual masturbation, and the use of a vibrator. Some women we have treated have expected ground-shaking experiences every time and have dismissed mild rhythmic contractions as "not the real thing." Explaining the range of experiences also helps to normalize a woman's sexual response and reduce worry.

Delayed Ejaculation

Perelman (2014) points out that delayed ejaculation is very rare (less than 3% of sexual dysfunction cases) and often misdiagnosed. To ensure accurate diagnosis and treatment, a detailed focused interview must tease out details of masturbatory practices as well as details of sexual fantasies and behaviors during partnered sex. Our clinical experience with this disorder is consistent with Perelman's (2014) observations that delayed ejaculation is often associated with idiosyncratic masturbatory practices. These practices have often been characterized by unusual speed, pressure, intensity, or duration of masturbation, as well as by unusual mechanisms or styles of masturbation such as rubbing against a pillow, bending the penis backward and moving back and forth on one's stomach, twirling the penis between

both hands as one would do to start a fire with a stick, or pressing the head of the penis between one's thumb and two forefingers. We have had patients who have described their masturbation using any one of the above styles.

In delayed ejaculation cases in which idiosyncratic masturbatory styles have been used, it is helpful to explain to the man with delayed ejaculation that his masturbatory style may have conditioned his body to respond primarily to similar sensations. Therapy is focused on helping the man to respond to sensations that are more likely to occur during sex with a partner. This includes masturbatory practice using one's hand with a stroking motion and using lubrication. Men who are learning new masturbatory practices must be cautioned that practicing a new style may take time before becoming proficient in producing orgasm. In addition, there should be a prohibition on the idiosyncratic style. In some cases, we have had men who have experienced rapid success within very few sessions while others have taken months to achieve success.

In other delayed ejaculation cases, the problem is a disparity between the realities of sex with a partner compared with preferred sexual fantasies during masturbation (Perelman, 2014) or preferred sexual stimulation. In such cases, it is important for the therapist to encourage the patient to use whatever fantasies are most stimulating and to communicate the approach to sex that is most arousing. Some men feel that they are cheating on their partner if they use fantasies of other partners or of fetish behavior. This should be discussed and normalized. Men should also be encouraged to discuss with their partner the approach and behaviors that are most stimulating. Patients should be cautioned to discuss this with their partner in a positive way. For example, don't say "You don't stimulate me enough during foreplay"; rather, say "I really like it when you stimulate me for a longer time during foreplay."

Premature (Early) Ejaculation

In Chapter 5, we discussed the work of Waldinger (2008) who described four subtypes of premature (early) ejaculation. In cases of lifelong premature (early) ejaculation, in which a biological component is likely, patients often benefit from a pharmacological approach. In cases in which there is a misunderstanding about premature (early) ejaculation, accurate and normative information is helpful for the man experiencing premature (early) ejaculation and his partner. Complaints of premature ejaculation are often associated with misunderstandings about sex and are also often "smoke screens" for relationship problems. Common misunderstandings include an unrealistic expectation about the length of time thrusting should last before ejaculation and the belief that sex ends as soon as ejaculation occurs.

In many cases of premature ejaculation, we direct our initial discus-

sion to the question, "Why do you have sex?" With this question (or a similar one), we try to elicit a man's hopes and goals when he has sex. After some thought, most men can generate quite a number of reasons. "To have pleasure" or "because it feels good" may be men's most common responses. We point out that people have sex for a variety of reasons: to experience pleasure, to express love and affection, to make up after an argument, to have children, to make oneself feel better, to please a partner, to validate attraction, and so on. Moreover, the reasons may change from occasion to occasion. The goal of this general discussion is to impress upon our patients that pleasure or pleasuring, and all of the other reasons people have sex, are not dependent on the length of time between intromission and orgasm. Furthermore, the length of time a man "lasts" should be looked upon as but one small part of the whole sexual exchange. Indeed, the primary goal of our question and the ensuing discussion is to encourage the couple to focus on general pleasuring rather than orgasm. We encourage the partners to continue having intercourse even after ejaculation. We hasten to add, however, that this technique may be helpful for focusing a couple's attention on pleasure rather than orgasm, but it may not be desirable for couples practicing "safer sex"; that is, if a man does not withdraw after ejaculating, his condom may come off as detumescence begins. For men wearing condoms during sexual relations, other strategies may be helpful.

Our purpose in discussing sexual purpose and different technique is to take the pressure off the timing of ejaculation and emphasize the total sexual relationship. This approach usually results in a couple's report of a more satisfying relationship.

A second question that we ask men experiencing premature (early) ejaculation is "What do you believe is causing the problem?" As is the case with all sexual problems, the meaning attributed to the problem by each partner should be explored thoroughly. In some cases of premature (early) ejaculation, the female partner may express anger because her sexual needs are going unmet. Similarly, some women may believe that men have more control over ejaculation than is truly the case; a woman may interpret her partner's "haste" as his way of being thoughtless or inconsiderate. However, we have yet to have a patient who can control his ejaculation so expertly that he can purposely reach orgasm quickly in order to hurt his partner's feelings. On the contrary, most men who seek treatment for premature (early) ejaculation want desperately to increase their latency so that they can please their partners. They tend to be embarrassed and confused about their difficulty.

We want to point out, however, that a focus on premature (early) ejaculation can be a distraction from a deeper problem. If the root cause is, for example, a distressed relationship, therapy directed at improving the relationship may also decrease the focus on premature (early) ejaculation.

When you believe that a couple has no sexual misunderstandings and has a compatible relationship, then other behavioral strategies may be helpful. In heterosexual couples, emphasis can be placed on bringing the female partner to orgasm before or after penetration. It can also be suggested that a sexual encounter can include more than one orgasm for the male. Thus, if a male ejaculates quickly, this can be considered the first pleasure experience of a more prolonged sexual episode that may include an additional experience of intercourse and orgasm. After a refractory period following orgasm, most men can obtain an erection a second and even a third time depending on their age. Older males may have a longer refractory period and have more difficulty obtaining subsequent erections.

Female Sexual Interest Arousal Disorder

A lifelong and generalized problem of female sexual interest arousal disorder (FSIAD) is most often associated with chronic depression, sociocultural/religious factors, and past negative messages and experiences related to sex. When depression is the root cause of FSIAD, pharmacotherapy and cognitive-behavioral therapy are effective treatment approaches. When the main contributions to FSIAD are of a sociocultural/religious nature, therapy has to be sensitive to not disparage or offend a person's beliefs. In some cases, a therapist may be able to work with the input from a person's religious organization to develop a strategy that is acceptable and can promote change.

When there exists significant negative thinking and messages contributing to FSIAD, Brotto and Luria (2014) suggest the use of (1) cognitive-behvioral therapy to challenge negative thinking and (2) mindfulness-based interventions which focus women on the present moment and cultivate active awareness of the body in an accepting, nonjudgmental, and compassionate manner.

When low desire is a product of long-standing attitudinal and experiential factors, therapy must focus on processing the source and reaction to the important background influences. The patient must develop an understanding of the influences contributing to FSIAD. Because insight alone rarely results in any positive change, increasing sexual interest may only develop following positive sexual thoughts and experiences. Exposure to erotica may be used in some cases to promote change. Before discussing the use of erotica in the treatment of FSIAD, a brief discussion is necessary to define terms and clarify our position. When we use the term "erotica," we are referring to the depiction of consensual sexual relations, whereas the term "pornography" refers to the depiction of coercive sexual relations. Our position regarding the use of erotica is similar to that articulated by the Sexuality Information and Education Council of the United States (SIECUS):

> When sensitively used in a manner appropriate to the viewer's age and developmental level, sexually explicit visual, printed, or on-line materials can be valuable educational or personal aids, helping to reduce ignorance and confusion and contributing to a wholesome concept of sexuality. However, the use of violence, exploitation, or degradation, or the portrayal of children in sexually explicit materials is reprehensible. Minors should be legally protected from all forms of sexual exploitation (retrieved from *www.siecus.org*).

We appreciate, however, that some readers and patients may have different views on the use of erotica, and we respect their views. We also appreciate that it can be challenging to find erotica that is healthy in the way that it depicts less powerful persons, including women. *Sexopedia* (Hooper, 2002), previously described, is very tasteful and acceptable to many individuals.

Use of erotic materials should proceed only after a thorough discussion with the patient. Objections to pornography, particularly the objectification and degradation of women, should be addressed, so that there are no barriers to accepting and experiencing erotic materials positively. When you are confident that your patient can use selected erotic materials without negative objections, then the nature and details of exposure should be discussed. Use of erotica should be approached as a sexual experience, paying attention to mood, setting, and other important ingredients of a satisfying encounter. It is also crucial to advise the patient to view erotica without being a movie or literary critic! We have had patients return after viewing erotica and comment on the poor cinematography. Developing your own library of materials that you have previewed (so that you can make knowledgeable recommendations to patients) is recommended.

When FSIAD is linked only to a current partner or circumstance, change can usually be achieved more easily. Solving the problems with the current partner or circumstance must be addressed first; then a return of sexual interest can be facilitated.

Male Hypoactive Sexual Desire Disorder

Low sexual desire in males or hypoactive sexual desire disorder (HSDD) is commonly a result of hypogonadism and other biomedical factors. In cases in which biomedical factors have been ruled out, many of the same psychosocial causal factors responsible for FSIAD may also be operating in males. Depression, sociocultural/religious factors, and past sexual trauma or negative messages all may play a role in contributing to low sexual desire in males. In such cases, treatment can proceed along the same lines as treatment for FSIAD. In addition, we have also seen men present with HSDD following a history of ED and avoidance of sexual stimulation.

Some men are so devastated by their experience of ED that they will avoid sex and sexual stimulation at all costs. Their thinking is, "Why should I even think about sex when it only leads to disappointment and humiliation?" Viewing pornography only serves to remind such men of what they can't have and what they can't do. When low desire in men is linked to a history of ED, then a protocol for assessing and treating ED should be initiated.

Low desire in men may also be linked to hidden or suppressed sexual desires (Meana & Steiner, 2014). Men may present for treatment of HSDD and express that they have no desire for partnered sex but in reality their sexual desire is being expressed through their use of pornography or other means. In a case treated by one of us (J. P. W.), a 75-year-old man presented with HSDD. After a comprehensive assessment, it was found that he had normal levels of testosterone, he was not taking any medications, and he had no other medical risk factors. He stated that he had never married and in fact he never had a girlfriend. Initially he stated that he never had a sexual experience with a female even though he was attracted to females and not males. After a number of therapy sessions, it was learned that he had a sexual experience with a woman when he was 21 years old; but, in that experience, he was extremely nervous and lost his erection. The female partner responded with a great deal of upset and humiliated him with sarcastic remarks. He was so shaken by this experience that he never attempted to develop a romantic relationship again.

He found that fantasies of tying women up were sexually arousing and he continued with these fantasies throughout his life. When he came into treatment, he stated that he was spending up to 10 hours a day looking at bondage pornography on the Internet and "photo-shopping" the heads of women he knew (from photos he secretly shot) onto the bodies of women in bondage pornography. It is interesting that this man presented with a complaint of HSDD yet he was maintaining a very high level of sexual desire but expressed only through viewing erotic images and masturbating. The treatment that followed was not directed at HSDD but rather evolved into a long term therapy aimed at reducing sexual and social anxiety, increasing self-esteem, and developing social skills with women.

HSDD is sometimes present when sexual desire is suppressed. We have treated a number of men who are in heterosexual marriages but who have either secretly had sexual relations with men or have consistently fantasized about same-sex relations during masturbation. In one such case treated by one of us (J. P. W.), a professional man named Lew, age 55, presented with HSDD. He and his wife had been married 30 years and had two adult sons but had not had any sexual relations for 10 years. Lew described a very contentious relationship punctuated by frequent fights over the lack of sex. Although neither Lew nor his wife considered themselves alcoholics, they each drank a bottle of wine nightly. Fighting would typically evolve as they

drank. The next morning, each would be friendly and then go off to work and function successfully in their professional jobs.

Lew was being seen individually since his wife refused to attend therapy because she stated that it was Lew's problem and not hers. Lew disclosed that he had no sexual desire for his wife. As an experiment, the couple stopped drinking for a week and, during that time, the couple did not fight. Lew reported, however, that whether he was drinking or not, he did not have any sexual desire for his wife even when they were getting along. After about six sessions, Lew disclosed that he used fantasies of sex with men during masturbation. Whenever he traveled, he would purchase gay pornography and masturbate. He denied ever having any actual contact with males and he never considered himself homosexual. Although he stated that he did find women attractive, he admitted that he had always exclusively used same-sex fantasies during masturbation. He also admitted that he never had strong sexual desire for his wife and when he started to avoid sex, the couple started fighting more and more.

Lew presented with HSDD since he experienced no sexual desire for his wife and little desire for women in general. Since he never identified himself as homosexual, he accepted himself as a man with low sexual desire and he was seeking treatment to increase his desire. Low desire was, of course, not his problem; rather, his problem was his inability to accept his same-sex attractions.

One final area to consider in treating men who present with HSDD is the possibility of asexuality. Asexuality is a condition in which there is a lack of sexual attraction toward anyone or anything, and therefore a lack of sexual orientation. A person who is asexual experiences no sexual desire. Yule, Brotto, and Gorzalka (2014) have identified possible biological markers for this condition which has a prevalence of about 1% of the population. Although asexual individuals may present for treatment for HSDD, the distinguishing characteristic is the lack of stress or anxiety in relation to the lack of sexual desire (Brotto, Knudson, Inskip, Rhodes, & Erskine, 2010). It is therefore a misdiagnosis to consider asexuality a variant of HSDD.

Genito-Pelvic Pain/Penetration Disorder

Genital pain associated with sexual activity presents an especially complex array of potential biomedical and psychosocial factors for consideration and demands a multidisciplinary assessment and coordinated treatment approach. Bergeron, Rosen, and Pukall (2014) underscore the importance of a simultaneous treatment model when dealing with all sexual pain disorders. In addition to the importance of the medical and psychological assessment and treatment, physical therapy also plays an important role in addressing pain disorders (Bergeron et al., 2002; Gentilcore-Saulnier et al., 2010). Physical therapists are able to provide patients with therapy and

education specifically focused on pelvic floor musculature. Physical therapy may also include EMG biofeedback as well as *in vivo* practice of graduated manual insertion.

In sexual pain disorders, negative thoughts of oneself as well as of sex more generally are often present and need to be addressed. The use of cognitive restructuring in CBT along with pain management strategies has been found to be an effective treatment strategy for women presenting with genital pain disorders including lifelong vaginismus (Beregeron et al., 2014; van Lankveld et al., 2006).

WORKING WITH COUPLES

It is important to understand that when working with couples a patient's perception of his or her partner's motivation for sex may not always be because of sexual desire. ("Partner" in this case is the person without the sexual problem.) In many cases it is certainly true that a partner's frustration over sexual dysfunction is due to unfulfilled sexual desire; however, it is also true that the partner's negative reaction may have more to do with issues of needing validation, feelings of rejection, worries about one's attraction and desirability, or a need for reassurance of gender identity. These psychological reasons for sex must be identified and addressed in therapy in order to reduce performance anxiety. Addressing these psychological issues will also more accurately focus therapy toward a more lasting and comprehensive solution.

An example of this important issue can be found in a recent case one of us (J. P. W.) treated. Peter was a married 74-year-old man presenting with complaints of ED and HSDD. Peter reported that his 30 years of marriage to his 70-year-old wife, Evelyn, was his second marriage following a divorce. Peter was a very religious man and because his first marriage was never annulled within his church, he believed that he could not receive communion and participate fully in his faith. After 10 years of marriage, during which time the couple enjoyed an active sexual relationship, Peter had a strong desire to fully participate in his faith and he sought counseling from a priest. He was told by the priest that he could fully participate in the church if he did not have sex with his wife. Peter was very much a man who thought in black-and-white terms and acted upon this priestly advice and abruptly stopped having sex with Evelyn but never told her why. For the next 20 years Peter avoided sex and physical intimacy with Evelyn and, understandably, Evelyn became angry, disheartened, frustrated, and perplexed as to what had happened. The fighting and tension finally drove Peter to leave and stay with his adult daughter from his first marriage. His daughter then called Evelyn and told her the full story that Peter had, in sorrow, related to her. Upon return, Peter sought counsel from another

priest who told Peter that it was acceptable to resume sex with Evelyn and fully participate in church. At this point, and in spite of her anger, she became very demanding of sex. Peter, who was now extremely guilty and remorseful, interpreted her demand for sex as a reflection of her great sexual desire. He stated in therapy that at all costs he would try to have intercourse with Evelyn to fulfill what he saw as her sexual needs. Peter's age, however, had brought with it a slew of medical conditions that interfered with his erectile ability. He was, nonetheless, prepared to go through any medical treatment to restore his erectile capacity and make up for lost time. Evelyn, however, was psychologically wounded and not in need of fulfillment for sexual desire. What she needed from Peter was validation that she was desirable and that the marriage was not a waste and recognition that her womanhood was intact. Peter's words and expressions of physical intimacy were ultimately more meaningful and important than heroic efforts to restore a firm erection.

This case is a reminder that what may be obvious to psychologically minded therapists is not always obvious to patients. This couple's lack of communication and sexual misunderstandings underscore common issues that emerge in treating couples. The therapist cannot narrowly respond to a couple's understanding of their sexual problem but must look at the whole picture of a couple's interaction and history to accurately assess the problem and accurately focus treatment.

WORKING WITH INDIVIDUALS WITHOUT PARTNERS

It is important to prepare individuals who enter therapy without partners for future sexual encounters. Much of the work with single individuals is often focused on helping them to develop social and sexual skills, select compatible partners, and increase sexual knowledge. Many of the single individuals we see in therapy have been either wounded by previous sexual failures or have avoided sex for fear of failure. It is important to prepare a single patient to be able to approach a future sexual encounter with the knowledge of what conditions for sex and what characteristics of a partner are most favorable for producing a rewarding sexual experience. Therapy with a single patient can help that patient to negotiate the conditions under which sex occurs and select a partner who is flexible and supportive. Therapy can also be used to role-play and rehearse discussions about sexual preferences as well as sexual failures, and therapy can also be used to teach sexual behavior strategies to increase pleasure and fulfillment. While there are certainly advantages to be able to work with a couple, there is certainly much that can be achieved with single patients as well.

TABLE 14.1. Likely Etiologies and Possible Treatments for Desire-Phase Dysfunctions in Men and Women

Dysfunction	Likely etiologies	Possible treatments
	Men	
Male hypoactive sexual desire (acquired/ generalized)	*Medical:*	
	1. Low testosterone (various causes)	1. Testosterone (endocrinologist, urologist)
	2. Elevated prolactin (pituitary adenoma)	2. Dopamine agonist (endocrinologist)
	3. Medication side effect	3. Medication adjustment
	4. Medical disease	4. Medical treatment
	Psychosocial:	
	1. Depression	1. Psychotherapy
	2. Worry/anxiety	2. Psychotherapy
	3. Sexual trauma	3. Trauma therapy
	4. Sexual performance anxiety	4. Sensate focus, erotic exposure, fantasy training
Male hypoactive sexual desire (acquired/specific)	*Medical:* None	
	Psychosocial:	
	1. Partner conflict	1. Couple therapy
	2. Sexual performance anxiety	2. Sensate focus
	3. Environmental interference	3. Environmental adjustments, erotic exposure, fantasy training
Male hypoactive sexual desire (lifelong/ generalized)	*Medical:*	
	1. Endocrine problem	1. Medical treatment (endocrinologist)
	2. Other chronic illness	2. Medical treatment
	3. Genetic	3. None
	Psychosocial:	
	1. Sexual trauma	1. Trauma therapy
	2. Negative sex messages	2. Educational information, sensate focus, desensitization
	3. Low self-esteem or poor self-image	3. Psychotherapy, sensate focus, desensitization
Male hypoactive sexual desire (lifelong/specific)	*Medical:* None	
	Psychosocial:	
	1. Sexual orientation dysphoria/confusion	1. Psychotherapy/counseling
	2. Sexual trauma	2. Trauma therapy
	3. Negative sex messages	3. Educational information, sensate focus, desensitization

(*continued*)

TABLE 14.1. (*continued*)

	Women	
Female hypoactive sexual desire (acquired/ generalized)	*Medical:* 1. Hormone imbalance 2. Medication side effect 3. Medical disease	1. Hormone therapy 2. Medication adjustment 3. Medical treatment
	Psychosocial: 1. Depression 2. Worry/anxiety 3. Sexual trauma	1. Psychotherapy 2. Psychotherapy 3. Trauma therapy
Female hypoactive sexual desire (acquired/specific)	*Medical:* None	
	Psychosocial: 1. Partner conflict 2. Environmental interference	1. Couple therapy 2. Environmental adjustments, erotic exposure, fantasy training
Female hypoactive sexual desire (lifelong/ generalized)	*Medical:* 1. Chronic disease	1. Medical treatment
	Psychosocial: 1. Sexual trauma 2. Negative sex messages 3. Low self-esteem or poor self-image	1. Trauma therapy 2. Educational information, sensate focus, desensitization 3. Psychotherapy, sensate focus, desensitization
Female hypoactive sexual desire (lifelong/specific)	*Medical:* None	
	Psychosocial: 1. Sexual orientation dysphoria/confusion 2. Sexual trauma 3. Negative sex messages	1. Psychotherapy/counseling 2. Trauma therapy 3. Educational information, sensate focus, desensitization

TABLE 14.2. Likely Etiologies and Possible Treatments for Arousal-Phase Dysfunctions in Men and Women

Dysfunction	Likely etiologies	Possible treatments
	Men	
Male erectile disorder (acquired/ generalized)	*Medical:*	
	1. Diabetes, neurological disease, vascular disease	1. Medical treatment, PDE-5 inhibitors, vasoactive gels and injection, penile implant
	2. Low testosterone	2. Testosterone therapy (urologist or endocrinologist)
	3. Elevated prolactin	3. Dopamine agonist (endocrinologist)
	4. Other medical disease	4. Medical treatment, Viagra
	Psychosocial:	
	1. Performance anxiety	1. Sensate focus
	2. Depression	2. Psychotherapy
	3. Worry/anxiety	3. Psychotherapy
	4. Sexual trauma	4. Trauma therapy
Male erectile disorder (acquired/specific)	*Medical:* None	
	Psychosocial:	
	1. Partner conflict	1. Couple therapy, sensate focus
	2. Sexual orientation dysphoria/confusion	2. Psychotherapy, counseling, sensate focus
	3. Environmental interference	3. Environmental adjustment
Male erectile disorder (lifelong/ generalized)	*Medical:*	
	1. Endocrine problem	1. Endocrine therapy
	2. Other chronic illness	2. Medical treatment, Viagra, implant, vasoactive injection
	Psychosocial:	
	1. Severe psychological disorder	1. Psychotherapy
Male erectile disorder (lifelong/specific)	*Medical:* None	
	Psychosocial:	
	1. Sexual trauma	1. Trauma therapy, PDE-5 inhibitors
	2. Sexual orientation dysphoria/confusion	2. Psychotherapy/counseling
	3. Negative sex messages	3. Educational information, sensate focus, desensitization

(*continued*)

TABLE 14.2. (*continued*)

	Women	
Female sexual arousal disorder (acquired/ generalized)	*Medical:* 1. Menopausal 2. Other medical disease	1. Hormone therapy, lubricant 2. Medical treatment
	Psychosocial: 1. Performance anxiety 2. Depression 3. Worry/anxiety	1. Sensate focus 2. Psychotherapy 3. Psychotherapy
Female sexual arousal disorder (acquired/specific)	*Medical:* None	
	Psychosocial: 1. Partner conflict 2. Environmental interference	1. Couple therapy, lubricant 2. Environmental adjustment, lubricant
Female sexual arousal disorder (lifelong/ generalized)	*Medical:* 1. Congenital endocrine problem 2. Other medical condition	1. Endocrine therapy 2. Medical treatment
	Psychosocial: 1. Sexual trauma 2. Negative sex messages	1. Trauma therapy 2. Educational information, sensate focus, desensitization
Female sexual arousal disorder (lifelong/specific)	*Medical:* None	
	Psychosocial: 1. Sexual trauma 2. Sexual orientation dysphoria/confusion 3. Negative sex messages	1. Trauma therapy 2. Psychotherapy/counseling 3. Educational information, sensate focus, desensitization

TABLE 14.3. Likely Etiologies and Possible Treatments for Orgasm-Phase Dysfunctions in Men and Women

Dysfunction	Likely etiologies	Possible treatments
Male delayed orgasm (acquired/generalized)	*Medical:* 1. Substance abuse 2. Medication effect 3. Other medical	 1. Substance abuse therapy 2. Medication adjustment 3. Medical treatment
	Psychosocial: 1. Sexual trauma 2. Insufficient stimulation 3. Performance anxiety 4. Unspecified psychological problems	 1. Trauma therapy 2. Educational information, vibratory stimulation, lubrication, erotic exposure 3. Sensate focus 4. Psychotherapy
Male delayed orgasm (acquired/specific)	*Medical:* None	
	Psychosocial: 1. Partner conflict 2. Partner technique or solo technique	 1. Couple therapy 2. Educational information
Male delayed orgasm (lifelong/generalized)	*Medical:* 1. Congenital medical disease	 1. Medical treatment
	Psychosocial: 1. Unspecified psychological 2. Sexual orientation or gender dysphoria, confusion 3. Idiosyncratic masturbation style	 1. Psychotherapy 2. Psychotherapy/ counseling 3. Masturbation retraining
Male delayed orgasm (lifelong/specific)	*Medical:* None	
	Psychosocial: 1. Sexual trauma 2. Negative sex messages 3. Sexual orientation or gender dysphoria, confusion	 1. Trauma therapy 2. Educational information, sensate focus, desensitization 3. Psychotherapy/ counseling

(*continued*)

TABLE 14.3. (*continued*)

Premature ejaculation (acquired/generalized)	*Medical:* 1. Unknown	1. SSRI, Tramadol
	Psychosocial: 1. Performance anxiety 2. Misinformation, poor technique	1. Sex therapy approach as outlined in this text 2. Educational information
Premature ejaculation (acquired/specific)	*Medical:* None	
	Psychosocial: 1. Couple conflict 2. Performance anxiety	1. Couple counseling, information 2. Sex therapy as outlined in this text
Premature ejaculation (lifelong/generalized)	*Medical:* 1. Genetic, unknown	1. SSRI, Tramadol
	Psychosocial: 1. Performance anxiety 2. Misinformation, poor technique	1. Sex therapy as outlined in this text 2. Educational information
Premature ejaculation (lifelong/specific)	*Medical:* None	
	Psychosocial: 1. Performance anxiety 2. Partner conflict 3. Misinformation, poor technique	1. Sex therapy as outlined in this text 2. Educational information, couple therapy 3. Educational information
Female orgasmic disorder (acquired, generalized)	*Medical:* 1. Disease process 2. Substance abuse 3. Medication side effect	1. Medical treatment 2. Substance abuse therapy 3. Medication adjustment
	Psychosocial: 1. Performance anxiety 2. Sexual trauma 3. Depression 4. Worry/anxiety	1. Sensate focus 2. Trauma therapy 3. Psychotherapy 4. Psychotherapy

(*continued*)

TABLE 14.3. (*continued*)

Female orgasmic disorder (acquired/ specific)	*Medical:* None	
	Psychosocial: 1. Partner conflict 2. Poor partner technique 3. Environmental interference	1. Couple therapy, information, sensate focus 2. Educational information 3. Environmental adjustment
Female orgasmic disorder (lifelong/ generalized)	*Medical:* 1. Various medical conditions	1. Medical treatment
	Psychosocial: 1. Sexual trauma 2. Negative sex messages 3. Poor technique, lack of experience	1. Trauma therapy 2. Educational information, sensate focus, desensitization 3. Educational information, masturbation training, vibratory stimulation
Female orgasmic disorder (lifelong/ specific)	*Medical:* None	
	Psychosocial: 1. Sexual trauma 2. Negative sex messages	1. Trauma therapy 2. Educational information, sensate focus, desensitization

TABLE 14.4. Likely Etiologies and Possible Treatments for Sexual Pain Disorders in Men and Women

Dysfunction	Likely etiologies	Possible treatments
	Men	
Male pain (acquired/generalized)	*Medical:*	
	1. Peyronie's disease	1. Surgical or medical treatment
	2. Urinary tract	2. Medical treatment
	3. Genital injury	3. Urology
	Psychosocial:	
	Somatization disorder, hypochondriasis	Psychotherapy
Male pain (acquired/specific)	*Medical:* None	
	Psychosocial:	
	1. Malingering, avoidance	1. Psychotherapy
	2. Partner technique	2. Educational information
Male pain (lifelong/generalized)	*Medical:*	
	1. Congenital anatomical (stricture)	1. Medical/surgical treatment
	Psychosocial:	
	1. Somatization disorder	1. Psychotherapy
Male pain (lifelong/specific)	*Medical:* None	
	Psychosocial:	
	1. Somatization disorder	1. Psychotherapy
	2. Malingering, avoidance	2. Psychotherapy
	Women	
Female pain (acquired/generalized)	*Medical:*	
	1. Infection, STD	1. Medical treatment
	2. Endometriosis	2. Medical treatment
	3. Menopausal	3. Hormone therapy, lubricant
	4. Lesions, tumors	4. Medical treatment
	Psychosocial:	
	1. Sexual trauma	1. Trauma therapy
	2. General anxiety	2. Psychotherapy
	3. Negative sex messages	3. Educational information, sensate focus, desensitization
	4. Fear of pain	4. Sensate focus, gradual *in vivo* insertion

(*continued*)

TABLE 14.4. (*continued*)

Female pain (acquired/specific)	*Medical:* None	
	Psychosocial: 1. Partner issues 2. Sexual trauma 3. Environmental interference	1. Couple therapy, sensate focus 2. Trauma therapy, sensate focus 3. Environmental adjustment
Female pain (lifelong/generalized)	*Medical:* 1. Congenital, anatomical 2. Vulvodynia 3. Idiopathic body chemistry, neurological	1. Surgical treatment 2. Medical treatment 3. Medical treatment
	Psychosocial: 1. Sexual trauma 2. Somatization disorder 3. Negative sex messages	1. Trauma therapy, sensate focus 2. Psychotherapy 3. Educational information, sensate focus, gradual *in vivo* insertion
Female pain (lifelong/specific)	*Medical:* None	
	Psychosocial: 1. Sexual trauma 2. Negative sex messages	1. Trauma therapy, sensate focus 2. Educational information, sensate focus, *in vivo* gradual insertion
Vaginismus (acquired/generalized)	*Medical:* 1. Lesions, tumors, genital trauma 2. Sequelae to vaginal pain disorder	1. Medical treatment 2. Medical treatment
	Psychosocial: 1. Sexual trauma 2. Sexual anxiety 3. Fear of pain	1. Trauma therapy 2. Educational information, sensate focus, desensitization 3. Sensate focus, gradual *in vivo* insertion

(*continued*)

TABLE 14.4. (*continued*)

Vaginismus (acquired/specific)	*Medical:* None	
	Psychosocial: 1. Partner issues 2. Sexual trauma 3. Environmental interference	1. Couple therapy, sensate focus 2. Trauma therapy, sensate focus 3. Environmental adjustment
Vaginismus (lifelong/generalized)	*Medical:* 1. Congenital, anatomical 2. Sequelae to vaginal pain disorder	1. Surgical treatment 2. Medical treatment
	Psychosocial: 1. Sexual trauma 2. Somatization disorder 3. Negative sex messages	1. Trauma therapy, sensate focus 2. Psychotherapy 3. Educational information, sensate focus, gradual *in vivo* insertion
Vaginismus (lifelong/specific)	*Medical:* None	
	Psychosocial: 1. Sexual trauma 2. Negative sex messages	1. Trauma therapy, sensate focus 2. Educational information, sensate focus, gradual *in vivo* insertion

PART IV
Other Important Concerns

In this final part of our book, we want to bring to the reader other concerns and guidance in the assessment and treatment of sexual dysfunction. It is a growing worry throughout all of medicine that so much time, money, and effort are spent on ineffective and unscientific approaches to treating human suffering. The treatment of sexual dysfunction has not escaped the foibles of charlatan approaches to offering solutions and has been confronted by its own unique set of problems.

In addition to addressing unscientific treatment of sexual dysfunction, we end by suggesting to the reader opportunities for professional development in the field of sexology. Interest in the clinical aspects of sexual problems has continued to grow over the past 14 years since our second edition and there are now more opportunities than ever before for professional training.

15

The Placebo Effect and Nonscientific Treatment of Sexual Dysfunction

Before exiting from our discussion of clinical treatment of sexual dysfunction, we wish to explore the world we live in today and the presence of beliefs for which evidence is not available or supportive. There are volumes written on this topic and, for the interested reader, we suggest the following excellent books: Bruce Hood's (2010) *The Science of Superstition*, Paul Offit's (2013) *Do You Believe in Magic?: The Sense and Nonsense of Alternative Medicine*, and Robert Park's (2008) *Superstition: Belief in the Age of Science*.

Pseudoscience as applied to medicine has been part of the history of mankind for hundreds of years. A notable example is homeopathy, founded by Samuel Hahnemann in 1796. Hahnemann believed that medical treatment should induce the same symptoms of the disease that is being treated; thus, if a vomiting illness is being treated, the medicine to treat vomiting should also induce vomiting (Offit, 2013). Furthermore, the homeopathic medicine should be diluted to the point that the active ingredient is no longer present, but that the "essence" of what was once there is still preserved. Though there is no scientific, theoretical basis for this idea, homeopathic medicine is alive and well today, with millions of dollars spent annually on these medicines.

Numerous other untested medications and herbal remedies are widely available for a host of ailments. The potential harm of any untested medication is that (1) it gives false hope to people in need of help; (2) patients in need of help may lose valuable time needed to effectively treat their problem, and, in some cases, it may be too late to obtain effective legitimate treatment; (3) money is spent on ineffective treatments; and (4) some such medicines actual cause harm. Since herbal remedies and other alternative treatments are unregulated, the ingredients may be poisonous or

cause infectious disease. For example, cyanide poisoning has been found in patients using Laetrile, an alternative medicine used to treat cancer (Offit, 2013).

WHY ARE PEOPLE SUSCEPTIBLE TO THE USE OF UNPROVEN MEDICAL TREATMENT?

There are a number of reasons why people (and especially people desperately looking for a cure for their problems) are vulnerable to pursuing and accepting treatments that are not empirically based.

Lack of Scientific Knowledge

Trained scientists are well aware of the nuances of scientific methodology. We know that valid research must control for extraneous variables and meet certain requirements to be accepted. We know that a valid research study must control for the placebo effect, the passage of time, subject bias, researcher bias, sample bias—and must be generalizable. We know the difference between controlled research and observational research, case studies and testimonials. Unfortunately, the general public does not know these differences and has no idea what is necessary for conducting research that has valid and reliable results. The fact that researchers obtained their results by utilizing a "randomized placebo-controlled cross-over experimental research design" may carry less weight in the public's eyes than that of a celebrity speaking out about his or her use of and belief in an herbal remedy for cancer or a diet to cure autism. Because of its lack of scientific knowledge, the general public is not able to discriminate important differences necessary to validate treatment efficacy.

Superstitious Behavior

Skinner (1947) observed that if pigeons are randomly given reinforcement of food, they develop stereotypical behavior such as turning on one foot, twisting, pecking, and flapping their wings. This may be labeled as "superstitious' behavior because the behavior of the pigeons has no influence on the delivery of food, yet the stereotypical behavior of the pigeons persists. This is best explained as a behavior controlled by a variable interval (VI) schedule of reinforcement. Reinforcement was delivered randomly while the pigeon was performing a behavior and this strengthened the probability of the behavior being repeated. As the behavior continued, it would again be reinforced (randomly) and strengthened some more.

People are also susceptible to superstitious behavior. If a person believes

that his or her actions will produce a certain outcome, then, when that outcome occurs (no matter when), the belief is strengthened. For example, if I believe that carrying a rabbit's foot will bring good luck, and sometime in the future I win a prize, I will attribute my winnings to carrying the rabbit's foot. Similarly, if I believe that vitamin C will cure my cold, and I take vitamin C, I will attribute the cure of my cold to vitamin C whenever my cold gets better.

Cognitive Dissonance

Cognitive dissonance is the description of what occurs when an individual holds two or more contradictory beliefs (Festinger, 1962). In order to reduce the upset of the contradictory beliefs, a person must justify his or her actions or change his or her beliefs. For example, one of us (J. P. W.) had a patient who had spent several thousand dollars to hear a motivational speaker explain how to reduce stress in one's life. Rather than state that he had wasted his money (which would have caused him more anxiety), the patient stated that "It was the best money I ever spent." The patient could not recount exactly what he had learned or how his anxiety was reduced, but he was convinced in the value he had received. Similar thinking may be operating when one invests time and money in medicines and treatments with no scientific basis.

Cultural, Religious, and Social Influences

Search "cultural superstition" on the Internet and thousands of examples of cultural-specific superstitions will be cited. While most of the examples may seem bizarre and amusing to those outside of specific cultures or countries, for those within the culture the superstition may make sense and even guide daily behavior and medical decisions. When the superstitious belief is promoted by one's religious leaders, the obeisance to and practice of the belief may be even more influential and powerful. We are all aware of tragic examples of parents refusing medical treatment for their dying child as they wait for divine intervention. Such examples underscore the power of acculturation in choosing treatments.

UNSCIENTIFIC TREATMENT OF SEXUAL DYSFUNCTION

It is clear to us and to other professionals who treat men and women experiencing sexual dysfunction that sexual dysfunction may be devastating. The experience of sexual dysfunction may result in depression and even suicide, and may be ruinous to a relationship. The men and women whom

we see are often distraught and desperate and seem prepared to do anything to remedy their sexual problem. Such desperation imbued in sexual dysfunction produces vulnerability to anything or anyone who promises a cure; this sets the stage for a powerful placebo effect.

Note the desperation and false beliefs of men writing to a homeopathic website for sexual help:

> Dear sir, I am 30 yrs. old guy due to bad habit of Masturbation. I am now facing problem of penis erection during sexual intercourse and cannot hold long enough to satisfy my partner due to pre-mature ejaculation, due to which my life is getting worse, kindly help me out with proper medication. (*www.homeo4happylife.com*)

> Sir my age is 26 and I have a problem of erectile dysfunction. My penis is not becoming that much erect wen I am excited and I discharge also within 1 minute . . . plz help me n suggest some medicine. (*www.homeo-4happylife.com*)

In fact, the early controlled trials of Viagra identified a placebo effect ranging from 13 to 24% (Buris, Gold, & Clark, 2001). By definition, a placebo is any medical intervention that has no demonstrable physiochemical effect; yet, up to almost a quarter of men taking a "sugar pill" experienced restored erectile function. It doesn't matter that Viagra produces positive results in men with ED between 63 and 82% of the time, the large placebo effect opens the door for unscientific treatments for ED. True testimonials can be obtained from up to a quarter of men who experience ED using alternative medicine, as indicated below:

> This is Jay calling about ViSwiss. This is the best non-prescription medicine I've ever taken. I take 1 in the morning and one at night. And between 22 and 24 mornings a month I wake up with an erection. If I take two (pills) 30 to 35 minutes before sexual activity I get as hard as a rock. Thank you. (*www.viswiss.com/success-stories.php*)

The Internet has endless citations for products and procedures to help men and women with every conceivable sexual problem. Some products are obvious hoaxes—for example, pills sporting names like "Bullet Proof," "Rock Hard," and "Lightning Rod"—while others are couched in scientific-sounding language and display "professional" anatomical charts explaining blood flow, nerve impulses, pharmacokinetics, and metabolism. What is missing, of course, are controlled research studies published in respectable peer-reviewed journals validating the products. Nonetheless, these unsubstantiated pharmaceutical products can sell for hundreds of dollars for a month's supply and promise successful treatment for ED, premature

ejaculation, low sexual desire, and penis enlargement. Penis enlargement or enhancement is also promised through various mechanical devices (weights and stretchers attached to the penis) and procedures (jelqing; *www.google.com/#q=jelqing*) as well as surgery. One of us (J. P. W.) treated a patient who had gone through surgery to enlarge his penis; unfortunately, he ended up with a severely deformed penis and chronic depression. The bottom line is that there are no validated procedures or pharmaceuticals that increase penile length or girth.

WHAT SHOULD PRACTITIONERS DO ABOUT UNFOUNDED SEXUAL MEDICINE BELIEFS?

One reason why we included this chapter on unfounded sexual medicine beliefs in our book is because we feel that to combat false medical beliefs, practitioners should be familiar with the false beliefs within their specialty. We have many patients who have wasted time and money investing in a multitude of unsubstantiated treatments who come to us with many questions. It has been of value to be knowledgeable regarding these pseudotreatments and products and to be able to explain to patients the differences between research-validated methodology and methodology that lacks validation. To combat pseudotreatments, practitioners should take time to explain legitimate treatment in concrete and understandable language. Certainly, if a patient comes to us who has used an untested product that he or she feels has helped, we will not dissuade them from using the product unless it is known to be harmful. Supporting and adding to the benefits of a placebo response makes clinical sense. Finally, we should all be aware that one reason for the success of psuedotreatments is that their practitioners often take the time to carefully listen to patients and satisfy patients' emotional needs. This is often in contrast to practitioners in the medical field who may come across as busy and uncaring.

16

Professional Training and Development

This chapter is designed to address two questions that you might have at this point: First, how do I obtain further training in the clinical treatment of sexual problems? And, second, how do I go about starting a therapy practice? Since the publication of the previous edition of this book, there have been many developments in the field of sexology to inspire, cultivate, and refine professional development. Most notable is the excellent website of the Kinsey Institute (*www.kinseyinstitute.org/resources/education.html#Other*). The Kinsey Institute has organized and identified a comprehensive list of sexology training opportunities in the United States, Canada, and abroad.

In addition to the Kinsey Institute, the Society for the Scientific Study of Sexuality (SSSS; *www.sexscience.org*) is also an excellent source of information for education, training, professional networking, and mentoring in the field of sexology. The aspiring student or new professional should review these sites for a multitude of professional training and development opportunities.

FURTHER TRAINING AND CONTINUED DEVELOPMENT

In addition to checking out the above websites, there are many other ways to further your knowledge of sexual health and dysfunction, and to hone your clinical skills. Here, we provide specific suggestions both for the student-in-training (at the postbaccalaureate level) and for the practicing professional (who has already received the terminal degree in his or her discipline). These suggestions are certainly not exhaustive, and we encourage you to be creative as you seek out further training.

For Students-in-Training

Find a Mentor

For those of you who are still students-in-training, our first piece of advice is to identify a senior-level professional in your discipline with an interest in human sexuality, and to ask that person to serve as your mentor. A mentor can help you to develop efficiently and effectively by providing ongoing research and clinical supervision, by informing you of recent developments in the field (well before these are available in print), and by serving as a role model for your development. Supervision from a fully credentialed mental health professional in your discipline—one with expertise in the treatment of sexual problems—is one of the wisest decisions you can make.

Take Didactic Courses

Regardless of whether you can locate a mentor, you should take didactic courses related to human sexuality. Today, when many universities offer online courses, you need not even live near an educational institution. (Of course, we caution you about the potential for charlatans and encourage you to seek out training only through accredited institutions.) It is important to emphasize that these courses should not be limited to your academic discipline; that is, if you are a student in a department of psychology, be sure to explore options in both other university departments (e.g., social work, human development, and nursing) and medical schools (e.g., departments of psychiatry, urology, gynecology, and family medicine). Also, be sure to consider courses in the basic sciences such as anatomy, endocrinology, and physiology. A well-rounded, biopsychosocial background in human sexuality will serve you well.

Obtain Clinical Training and Experience

If your training program has supervised clinical practica or clerkships that afford experience with the sexual dysfunctions, take them! You might also consider externships and internships that offer specialty tracks in sexuality.

Get Involved in Research

Finally, if you are at a research university, a medical center, or a teaching hospital, you can look for opportunities to become involved in sexuality research. Even well-known and internationally recognized scientists welcome volunteer assistants and enjoy nurturing junior colleagues. If you get involved with a research team, you will probably have the chance to present findings at local, national, or international meetings and conventions.

Establishing a Foundation of Knowledge

We advise that all health practitioners, regardless of their professional training as therapists or physicians, obtain a basic knowledge of human sexuality. Questions about sexual development, paraphilia, sexual orientation, gender identity, and sexual trauma are just a sampling of the concerns of patients presenting with sexual dysfunction. There are a number of complementary ways to achieve such a foundation.

Read an Introductory-Level, College Textbook

An efficient way to gain a broad and well-rounded perspective on human sexuality and recent research is to read one of the many fine human sexuality textbooks now available. For example, see *Understanding Human Sexuality*, by Hyde and Delameter (2011), or *The Psychology of Human Sexuality*, by Lehmiller (2014). There are many other fine textbooks available from most of the major academic publishing houses. We would advise that you read a recent book, however, because of the rapidly changing knowledge about human sexuality, sexual dysfunctions, and HIV and other STDs.

Read the "Classics"

Another valuable way to obtain foundation knowledge (and a sense of the history of the field) is to read the classic works in the field, such as Kaplan's (1974) *The New Sex Therapy* and Masters and Johnson's (1966, 1970) *Human Sexual Response* and *Human Sexual Inadequacy*. Maier's (2009) *Masters of Sex* is a well-researched historical review of the personalities, backgrounds, and synergy of these two famous individuals who represent the founding influences of sexual dysfunction research and therapy. The book points out that neither William Masters nor Virginia Johnson had any training in therapy, but nonetheless established therapeutic interventions that are still valued and in use today.

Read Recent Scientific Books on Human Sexuality

The field of sexology is the "poster boy" of multidisciplinary interests. We know of no other field that can boast of such a mixture of professionals that includes psychologists (clinical, developmental, evolutionary, and experimental), psychiatrists, social workers, urologists, obstetricians, gynecologists, primary care physicians, endocrinologists, anthropologists, and biologists. National and international conferences on sexology are almost always composed of an exciting mixture of various professionals and rarely (if ever) are composed of entirely one discipline. Consequently, it

is important to read recent books on the assessment and treatment of sexual dysfunction, such as Binik and Hall's (2014) *Principles and Practice of Sex Therapy, Fifth Edition*, but also to read classics from other disciplines such as an anthropological study of sex found in Ryan and Jetha's (2010) *Sex at Dawn*. Reading texts from other disciplines will enrich and expand your understanding of sexual behavior.

Stay Abreast of Current Developments by Reading Professional Journals

In addition to reading "classic" professional books, we encourage you to stay current by subscribing to at least one or two key journals in the field. Some of the notable journals in the field are as follows, but this is by no means an exhaustive list:

- *Archives of Sexual Behavior*, published by Springer, is the official publication of the International Academy of Sex Research.
- *Journal of Sex Research*, published by Taylor and Francis Group, is the official journal of the SSSS (see below).
- *Journal of Sexual Medicine*, published by Wiley, is the official journal of the International Society of Sexual Medicine.
- *Journal of Sex and Marital Therapy*, published by Taylor and Francis (Routledge), is a long-standing independent journal.

Join Professional Organizations Devoted to Research on Human Sexuality

It is a good idea to join at least one of the many professional organizations devoted to the dissemination of recent information about sexuality. Among the most well-known organizations are the following:

The American Association of Sex Educators, Counselors, and Therapists (AASECT) is devoted to the promotion of sexual health by the development and advancement of the fields of sex therapy, counseling, and education. Its mission is to provide professional education and certification of sex educators, counselors, and therapists, as well as individuals who supervise sex therapists in training. AASECT also encourages research related to sex education, counseling, and therapy, and supports the publication and dissemination of professional materials related to these fields. To achieve its mission, AASECT offers a broad range of professional education and training activities, including a certification program, an annual meeting, and the *Journal of Sex Education and Therapy*. For information, e-mail *info@aasect.org*.

The Society for the Scientific Study of Sexuality (SSSS) is an international organization dedicated to the advancement of knowledge about sex-

uality. It is the oldest organization of professionals interested in the study of sexuality in the United States. SSSS brings together an interdisciplinary group of professionals who believe in the importance of the production of quality research and the clinical, educational, and social applications of research related to all aspects of sexuality. It holds an annual meeting and publishes the *Journal of Sex Research*. Membership information can be obtained by e-mailing *thesociety@sexscience.org*.

The International Academy of Sex Researchers (IASR) is a scientific society whose objective is the promotion of high standards of research and scholarship in the field of sexual behavior by fostering communication and cooperation among scholars engaged in such research. Membership is contingent upon scientific productivity in the field. IASR holds an annual meeting (which alternates between the United States and other countries) and publishes the journal *Archives of Sexual Behavior*. Membership information can be obtained through its website, *www.iasr.org/cms/contact*.

A comprehensive list of professional organizations and research institutions devoted to human sexuality is as follows:

- American Association of Sex Educators, Counselors, and Therapists (AASECT)
- American Board of Sexology (ABS)
- Association for the Treatment of Sexual Abusers (ATSA)
- British Association for Sexual and Relationship Therapy (BASRT)
- Canadian Federation for Sexual Health
- Canadian Sex Research Forum
- European Federation of Sexology
- European Society of Sexual Medicine (ESSM)
- Flemish Society of Sexology
- German Society for Social-Scientific Sexuality Research
- Institute for Advanced Study of Human Sexuality
- Institute of Family and Sexuality Studies
- International Academy of Sex Research (IASR)
- International Association of Sexual Medicine (IAS-M)
- International Association for the Study of Sexuality, Culture and Society (IASSCS)
- International Association for the Treatment of Sexual Offenders (IATSO)
- International Institute for Trauma and Addiction Professionals (IITAP)
- International Society for Sexual Medicine (ISSM)
- International Society for the Study of Women's Sexual Health (ISSWSH)

- Magnus Hirschfeld Archive of Sexology at the Humboldt University of Berlin
- National Association for the Treatment of Abusers (NOTA)
- Sexology SA & The Academy for Sexology
- South Asia Institute for Human Sexuality
- Sexuality Information and Education Council of the United States (SIECUS)
- Society of Australian Sexologists
- Society for Sex Therapy and Research (SSTAR)
- Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues
- Society for the Advancement of Sexual Health
- Society for the Scientific Study of Sexuality (SSSS)
- World Professional Association for Transgender Health (WPATH) (previously called the Harry Benjamin International Gender Dysphoria Association)
- Kinsey Institute for Research in Sex, Gender and Reproduction
- Kurt Freund Laboratory

Seek Postdoctoral Training

If your life situation will allow you to make less money, and to live in another city for a year or two, you might seek more formalized training experiences. For example, you might consider supervised externships and postdoctoral training opportunities that are increasingly available in major cities and can be located through professional publications such as the American Psychological Association's *Monitor*.

STARTING A SEX THERAPY PRACTICE

The purpose of this section is to provide some guidelines for setting up a successful private practice that focuses on the assessment and treatment of sexual dysfunctions. Although we touch upon aspects of professional practice that may be classified as entrepreneurial, our primary goal is to discuss the components of professional practice that are unique to the specialty area of the sexual dysfunctions. Our belief is that the nitty-gritty of business, such as whether to rent or buy your office, how to hire support personnel, and what office equipment to select, can be addressed better in other sources. Therefore, we turn our attention to the following issues: certification and licensure, client recruitment, insurance reimbursement, and ethics.

Licensure and Certification: What's in a Name?

Licensing is legislation that protects and defines the role and duties of a therapist; certification legislation protects professional titles. To our knowledge, however, only Florida grants a specific licensure or certification for "sex therapist." Those professionals who call themselves sex therapists and who claim to be licensed or certified by a state board of professional regulations are usually licensed in a core discipline, such as psychology, social work, medicine, or nursing. As a result of the absence of state licensing or certification, it is possible for anyone to present him- or herself as a sex therapist without any credentials, training, or expertise.

AASECT (mentioned earlier) does offer a certification program. To be eligible, a professional needs to have a master's degree plus 3 years of professional experience in the field, or a doctorate, with 2 years of experience. In addition, the therapist must also have completed 300 hours of sex therapy supervised by an AASECT-certified therapist. Although a reasonable program, the AASECT certification procedure is not regulated on a state level and is not required for practice. There are many excellent sex therapists who do not take the trouble to obtain this certification.

In addition to the matter of licensing and/or certification, there is the related matter of what one should call oneself professionally (e.g., how to list oneself in the telephone directory). This is not a trivial matter. Consider for example, the following experience. One of us (J. P. W.) was called upon as an "expert" witness to give testimony in a criminal case regarding a sexual offense. The opposing attorney did his homework and attempted to disallow the testimony on the grounds that he was "merely a sex therapist" and not a professional expert. When it was demonstrated that the witness was a "licensed PhD clinical psychologist," who happened to have expertise in human sexuality, the testimony was allowed. A subsequent, informal survey of colleagues from across the country indicated that one earns more professional credibility by titling oneself in terms of primary professional training rather than as a "sex therapist."

Patient Recruitment

One's title may affect patient recruitment, although we know of no research that has addressed this issue. Many professionals now use personal websites that are linked to key search words such as "sex problems," "erectile dysfunction," and "sexual dysfunction." In addition to web searches, two other excellent sources of client referrals are other professionals (especially physicians) and satisfied clients. Because there is not much one can do, for ethical reasons, to enhance client-based referrals, we recommend the "other professionals" route.

Several strategies seem to be effective in alerting other professionals to your expertise, the clinical services you offer, and so on. First, a method that appears very useful is to give free talks to professional organizations, such as local primary care or family practice physicians. Of course, it is important that you gear your talk (vocabulary and content) to your audience, and that you be well prepared. A second method would be to provide in-service training to local practitioners, trainees, and clinics. In this way, you become known as a person who is comfortable and skilled in dealing with sexual dysfunctions. Third, once you are experienced, and only after you are very adept at handling difficult questions, you might try carefully selected interviews with the local news media (print and electronic). This can be slippery and dangerous ground, though, so beware! Reporters are not interested in you, they are interested in grabbing headlines, so be sure to establish the ground rules with any reporter before the interview. Finally, we have found that publishing research findings generates referrals from outside our local areas. So if you have an opportunity to do research, or to collaborate with other colleagues on research, you may find that this work provides some dividends in terms of clients. Moreover, involvement in research is stimulating and challenging in its own right.

It is also important to establish links with other professionals so that you will be able to provide the highest quality care. In our view, the clinical practices that serve clients best are those multidisciplinary services that aim to incorporate the latest biopsychosocial and technical advances in assessment and treatment. These practices tend to be associated with teaching hospitals and university clinics. If you are not a part of such a setting, you will have to organize a collaborative effort with other professionals in order to offer your clients comprehensive care.

To establish such a team, you should try to develop a working collaboration with professionals having several medical specialties: urologists, gynecologists, and endocrinologists. The urologist should be familiar with the comprehensive assessment, diagnosis, and treatment of male sexual complaints. Preferably, the urologist will be sensitive to psychosocial contributions to sexual dysfunctions and not just interested in biomedical solutions. A gynecologist is invaluable for the assessment of female disorders. Like urologists, gynecologists vary widely in their knowledge of and sensitivity to sexual problems. It is a positive sign if the gynecologist and urologist with whom you work recognize that the restoration of intercourse is not the only goal in helping clients with sexual problems. Finally, the last "core" physician is the endocrinologist, who will be needed to complete hormonal evaluations and to monitor hormone therapy when this is indicated. Also, because endocrinologists tend to be well informed about diabetes, a common precipitating cause of sexual dysfunction in men and women, it is very helpful to have a colleague in this area.

In addition to this "core" group, you will occasionally need to consult with a cardiologist (regarding the effects of hypertension, antihypertensive medications, and the effects of various forms of cardiac illness), a neurologist (regarding the influence of seizure disorders and other neurological problems upon sexual function), and an infectious disease specialist (regarding AIDS and other STDs). Finally, because there is always the need for general medical screening, it is good to know an internist or family practitioner to whom you can refer. Also, such "medical generalists" often need psychosocial colleagues to whom to refer their own patients, so they can be a good source of referrals.

We believe that it is feasible to be in private practice and to treat sexual problems. However, if this is your situation, we strongly encourage you to establish the kind of referral network or comprehensive team described earlier. To work without such collaboration and consultation, in our view, teeters dangerously close to the kind of professional "know-it-all-ism" that might lead to malpractice. Besides, it can be professionally lonely!

Insurance Reimbursement

Health care insurance, especially so-called mental health care insurance, continues to be difficult at times—not just for sex therapy, but for all psychotherapies. At this point in time, we do not know if the Affordable Health Care Act will be helpful or make the picture even more complex. Every practitioner has his or her horror stories to tell, and we are no different. Given the plethora of coverages, companies, and plans, it is difficult to provide a global statement. However, in our experience, insurance companies do not automatically reimburse for treatment if the recorded diagnosis is a sexual dysfunction. A diagnosis of depression or anxiety disorder may be justifiable and is reimbursable. Reimbursement for sexual dysfunction differs from insurance company to insurance company and therapists should be aware of the guidelines for reimbursement for each company with which they are dealing.

Ethics and Sex Therapy

We have previously described the absence of state-regulated licensing and/or certification. Perhaps it is true that part of the reason why such formal recognition is absent is that there is skepticism associated with the "sex therapist" label. The general public, and elected officials who represent them, may still be affected by the bad press associated with sex therapists during the 1960s and early 1970s. In a thoughtful text published by the Walk-In Counseling Center of Minneapolis, Schoener, Milgrom, Gonsiorek, Luepker, and Conroe (1990) point out that the human potential move-

ment of the 1960s resulted in considerable experimentation with types and practices of psychotherapy. Specifically, there were articles published in professional journals and presentations made at professional meetings that advocated the use of bizarre and unethical practices such as nude marathon sessions with clients and touching, hugging, kissing, and sexual intercourse with clients. Although the advocates of these unethical approaches were in the minority, the popular press magnified their message. Thus, a widespread impression of sex therapists as "flaky perverts" was created. Unfortunately, these impressions are still with us, and they are in the minds of some patients who enter therapy.

Because of this history, those who practice sex therapy today have to be impeccable professionals. Not only should we abide by the ethical standards of our professions, but we must also avoid even the appearance of impropriety. Although we do not have the space to elaborate upon all ethical violations that are to be avoided, we wish to mention the most important ones.

You must absolutely avoid sexual intimacies with clients and observe appropriate professional boundaries in your work. Because therapy inevitably places patients in a vulnerable position and creates a psychological dependence upon the therapist, a power differential exists that creates a potential for sexual victimization. In addition to the usual factors that contribute to patient vulnerability, the explicit discussion of intimate sexual material increases the potential for transference and countertransference to occur. Moreover, many persons who seek treatment for sexual dysfunctions have had a history of sexual abuse; these persons appear to be at increased risk of being revictimized by others, even therapists (Broden & Agresti, 1998). For these reasons, you must be especially sensitive to patient welfare. You should develop professional policies that protect against dual relationship violations.

Most professionals quickly dismiss this matter as not applying to them. However, surveys suggest that the prevalence of sexual abuse of patients by professionals (i.e., physicians, psychologists, social workers, and pastoral counselors) ranges from 3 to 18% (e.g., Holroyd & Brodsky, 1977); that is, 3–18% of those surveyed have admitted to having sexual contact with their clients on at least one occasion. Schoener et al. (1990) remind us that the single, most frequent basis for a malpractice suit against psychologists is sexual malpractice. Similarly, in a 1985 survey of social workers, the leading cause of legal claims was sexual contact with clients (Besharov, 1985). Furthermore, indirect evidence for the continuing problem comes from state legislatures.

Laws regulating the sexual misconduct of therapists fall into four categories: civil, criminal, reporting, and injunctive relief statutes. The theoretical underpinnings of the various laws, an overview of the advantages

and disadvantages of each category, and the laws as they exist in various states are reviewed in an article by Haspel, Jorgenson, Wincze, and Parsons (1997).

CONCLUDING COMMENTS

In this book, we have tried to present a first course in the assessment and treatment of sexual dysfunctions. In conjunction with supervised clinical training and experience, we hope that this book will help you to feel comfortable about and prepared to address the sexual difficulties of your clients. Moreover, we have broached many topics that we hope you will have found intriguing and that might encourage further study.

In the course of providing sex assessment and therapy, we have been impressed by the grateful responses of our patients. Many report that they are expressing their sexual concerns and secrets for the first time. This opportunity to discuss sexual matters openly and without shame can be therapeutic for many patients. Even more gratifying are those moments when, through the straightforward therapeutic approach described in this book, we can help our patients to reestablish sexual functioning, health, and satisfaction. We wish you many similar moments.

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